101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 614.00: HEALTH SAFETY NET PAYMENTS AND FUNDING

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Scope, Purpose, and Effective Date. 101 CMR 614.00 governs Health Safety Net payments and funding effective October 1, 2019~~7~~, including payments to a~~A~~cute h~~H~~ospitals and c~~C~~ommunity h~~H~~ealth c~~C~~enters and payments from a~~A~~cute h~~H~~ospitals and s~~S~~urcharge p~~P~~ayers. The criteria for determining services for which a~~A~~cute h~~H~~ospitals and c~~C~~ommunity h~~H~~ealth c~~C~~enters may be paid by the Health Safety Net are set forth in 101 CMR 613.00: *Health Safety Net Eligible Services.*

614.02: Definitions

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

340B Provider. An a~~A~~cute h~~H~~ospital or c~~C~~ommunity h~~H~~ealth c~~C~~enter eligible to purchase discounted drugs through a program established by § 340B of United States Public Law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their p~~P~~atients, and registered and listed as a 340B p~~P~~rovider within the United States Department of Health and Human Services, Office of Pharmacy Affairs (OPA) database. Services of a 340B pharmacy may be provided at on-site or off-site locations.

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

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

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

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

Assessed Charges. Gross pPatient sService rRevenue attributable to all pPatients less gGross pPatient sService rRevenue attributable to programs administered pursuant to Titles XVIII, XIX, and XXI of the Social Security Act. For each fFiscal yYear, assessed charges are determined using data reported in a hospital's cCost rReport for that fFiscal yYear.

Bad Debt. An account receivable based on services furnished to a pPatient that is
(a) regarded as uncollectible, following reasonable collection efforts consistent with the requirements in 101 CMR 613.06: *Allowable Bad Debt*;
(b) charged as a credit loss;
(c) not the obligation of a governmental unit or the federal government or any agency thereof; and
(d) not a rReimbursable hHealth sService.

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

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

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

Community Health Center. A health center operating in conformance with the requirements of § 330 of the Public Health Service Act (42 U.S.C. § 254b), including all cCommunity hHealth cCenters that file cost reports with the Center. Such a health center must
(a) be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51;
(b) meet the qualifications for certification (or provisional certification) by the MassHealth aAgency and enter into a pProvider agreement pursuant to 130 CMR 405.000: *Community Health Center Services*; and
(c) operate in conformance with the requirements of 42 U.S.C. § 254b.

Disproportionate Share Hospital (DSH). An aAcute hHospital where a minimum of 63% of the gGross pPatient sService rRevenue is attributable to Title XVIII and Title XIX of the Social Security Act or other government payers, including the Premium Assistance Payment Program Operated by the Health Connector and the Health Safety Net.

Eligible Services. Services eligible for Health Safety Net payment pursuant to 101 CMR 613.03: *Eligible Services Requirements.* Eligible sServices include
(a) rReimbursable hHealth sServices to lLow–iIncome pPatients;
(b) Medical Hardship; and
(c) bBad dDebt as further specified in 101 CMR 613.00: *Health Safety Net Eligible Services* and 614.00.

Emergency Bad Debt. The amount of uncollectible debt for e~~E~~mergency s~~S~~ervices that meets the criteria set forth in 101 CMR 613.06: *Allowable Bad Debt*.

Emergency Services. Medically n~~N~~ecessary s~~S~~ervices provided to an individual with an e~~E~~mergency m~~M~~edical c~~C~~ondition as defined in 101 CMR 613.02: *Definitions*.

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

Financial Requirements. An a~~A~~cute h~~H~~ospital's requirement for revenue that includes, but is not limited to, reasonable operating, capital, and working capital costs, and the reasonable costs associated with changes in medical practice and technology.

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

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

Gross Patient Service Revenue. The total dollar amount of a hospital's charges for services rendered in a f~~F~~iscal y~~Y~~ear.

Guarantor. A person or group of persons who assumes the responsibility of payment for all or part of an a~~A~~cute h~~H~~ospital's or c~~C~~ommunity h~~H~~ealth c~~C~~enter's charge for services.

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

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

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

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

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

(a) nonmedical services, such as social, educational, and vocational services;
(b) cosmetic surgery;
(c) canceled or missed appointments;
(d) telephone conversations and consultations;
(e) court testimony;
(f) research or the provision of experimental or unproven procedures; and

(g) the provision of whole blood, but the administrative and processing costs associated with the provision of blood and its derivatives are payable.

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

Hospital Licensed Health Center. A s~~S~~atellite c~~C~~linic that

(a) meets MassHealth requirements for reimbursement as a h~~H~~ospital l~~L~~icensed h~~H~~ealth c~~C~~enter as provided at 130 CMR 410.413: *Medical Services Required on Site at a Hospital-licensed Health Center*; and

(b) is approved by and enrolled with MassHealth's Provider Enrollment Unit as a h~~H~~ospital l~~L~~icensed h~~H~~ealth c~~C~~enter.

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

Indirect Payment. A payment made by an entity licensed or approved under M.G.L. chs. 175, 176A, 176B, 176G, or 176I to a group of p~~P~~roviders, including one or more Massachusetts a~~A~~cute h~~H~~ospitals or a~~A~~mbulatory s~~S~~urgical c~~C~~enters, that then forward the payment to member a~~A~~cute h~~H~~ospitals or a~~A~~mbulatory s~~S~~urgical c~~C~~enters; or a payment made to an individual to reimburse him or her for a payment made to an a~~A~~cute h~~H~~ospital or a~~A~~mbulatory s~~S~~urgical c~~C~~enter.

Individual Medical Visit. A face-to-face meeting at a c~~C~~ommunity h~~H~~ealth c~~C~~enter between a p~~P~~atient and a physician, physician assistant, nurse practitioner, nurse midwife, registered nurse, or paraprofessional for medical examination, diagnosis, or treatment.

Individual Payer. A patient or g~~G~~uarantor who pays his or her own a~~A~~cute h~~H~~ospital or a~~A~~mbulatory s~~S~~urgical c~~C~~enter bill and is not eligible for reimbursement from an insurer or any other source.

Institutional Payer. A s~~S~~urcharge p~~P~~ayer that is an entity other than an i~~I~~ndividual p~~P~~ayer.

Low--Income Patient. A p~~P~~atient who meets the criteria in 101 CMR 613.04(1): *General*.

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

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

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

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

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

Mental Health Visit. A face-to-face meeting between an individual or a family and a member of an interdisciplinary team under the medical direction of a psychiatrist within the community health center setting, for purposes of examination, diagnosis, or treatment.

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

Non-acute Hospital. A nonpublic hospital that is
(a) licensed by the Department of Public Health under M.G.L. c. 111, § 51 but not defined as an acute-care hospital under M.G.L. c. 111, s. 25B; or
(b) licensed as an inpatient facility by the Department of Mental Health under M.G.L. c. 19, § 19 and regulations promulgated thereunder but not categorized as Class VII licensees under the regulations.

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

Patient. An individual who receives or has received m~~M~~edically n~~N~~ecessary s~~S~~ervices at an a~~A~~cute h~~H~~ospital or c~~C~~ommunity h~~H~~ealth c~~C~~enter.

Pediatric Hospital. An a~~A~~cute h~~H~~ospital that limits services primarily to children and that qualifies as exempt from the Medicare Prospective Payment System (PPS).

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

Prospective Payment System (PPS) Rate. The Medicare Prospective Payment System rate for c~~C~~ommunity h~~H~~ealth c~~C~~enters set annually by CMS as described in 42 CFR 405.2467.

Provider. An a~~A~~cute h~~H~~ospital or c~~C~~ommunity h~~H~~ealth c~~C~~enter that provides e~~E~~ligible s~~S~~ervices.

Publicly Aided Patient. A person who receives a~~A~~cute h~~H~~ospital or c~~C~~ommunity h~~H~~ealth c~~C~~enter care and services for which a g~~G~~overnmental u~~U~~nit is liable in whole or in part under a statutory obligation.

Registered Payer List. A list of i~~I~~nstitutional p~~P~~ayers as defined in 101 CMR 614.05(3)(b).

Reimbursable Health Services. Eligible s~~S~~ervices provided by a~~A~~cute h~~H~~ospitals or c~~C~~ommunity h~~H~~ealth c~~C~~enters to u~~U~~ninsured and u~~U~~nderinsured p~~P~~atients who are determined to be financially unable to pay for their care, in whole or in part and who meet the criteria for l~~L~~ow-i~~I~~ncome p~~P~~atient; provided that such services are not eligible for reimbursement by any other public or third party payer.

Shortfall Amount. In a f~~F~~iscal y~~Y~~ear, the positive difference between the sum of allowable Health Safety Net costs for all a~~A~~cute h~~H~~ospitals and the revenue available for distribution to a~~A~~cute h~~H~~ospitals.

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

Source Year. The f~~F~~iscal y~~Y~~ear two f~~F~~iscal y~~Y~~ears prior to the regulation effective date, from which data is collected to calculate current payment rates, unless otherwise specified by the Health Safety Net Office through administrative bulletin.

Surcharge Payer. An individual or entity that
(a) makes payments for the purchase of health care h~~H~~ospital s~~S~~ervices and a~~A~~mbulatory s~~S~~urgical c~~C~~enter s~~S~~ervices; and
(b) meets the criteria set forth in 101 CMR 614.05(1)(a).

Surcharge Percentage. The percentage assessed on certain payments to a~~A~~cute h~~H~~ospitals and a~~A~~mbulatory s~~S~~urgical c~~C~~enters determined pursuant to 101 CMR 614.05(2).

Third Party Administrator. An entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee. A t~~T~~hird p~~P~~arty a~~A~~dministrator may provide client services for a self-insured plan or an insurance carrier's plan. A t~~T~~hird p~~P~~arty a~~A~~dministrator is deemed to use a client plan's funds to

pay for health care services whether the t~~T~~hird p~~P~~arty a~~A~~dministrator pays p~~P~~roviders with funds from a client plan, with funds advanced by the t~~T~~hird p~~P~~arty a~~A~~dministrator subject to reimbursement by the client plan, or with funds deposited with the t~~T~~hird p~~P~~arty a~~A~~dministrator by a client plan.

Total Acute Hospital Assessment Amount. An amount equal to $417,500,000 plus 50% of the estimated cost, as determined by the Secretary of Administration and Finance, of administering the Health Safety Net and related assessments in accordance with M.G.L. c. 118E, §§ 65 through 69.

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

Urgent Care Services. Medically n~~N~~ecessary s~~S~~ervices provided in an a~~A~~cute h~~H~~ospital or c~~C~~ommunity h~~H~~ealth c~~C~~enter after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing a p~~P~~atient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent c~~C~~are s~~S~~ervices are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent c~~C~~are s~~S~~ervices do not include p~~P~~rimary or e~~E~~lective c~~C~~are, as defined in 101 CMR 613.02: *Definitions*.

614.03: Sources and Uses of Funds

(1) Available Revenue.

(a) Except as provided in 101 CMR 614.03(1)(b), revenue available to fund p~~P~~rovider payments from the Health Safety Net Trust Fund consists of

1. revenue produced by a~~A~~cute h~~H~~ospital and n~~N~~on-acute h~~H~~ospital assessments and the surcharge on h~~H~~ospital s~~S~~ervices and a~~A~~mbulatory s~~S~~urgical c~~C~~enter s~~S~~ervices payments, less

a. 50% of the estimated cost, as determined by the Secretary of Administration and Finance, of administering the Health Safety Net and related assessments in accordance with M.G.L. c. 118E, §§ 65 through 69;

b. any amount designated to be transferred to the MassHealth Delivery System Reform Trust Fund pursuant to M.G.L. c. 118E, § 66 or otherwise required by law; and

c. any amount designated to be transferred to the Non-acute Care Hospital Reimbursement Trust Fund established in M.G.L. c. 29, s. 2WWWW pursuant to M.G.L. c. 118E, § 66 or otherwise required by law;

2. funds authorized to be transferred from the Commonwealth Care Trust Fund;
3. amounts previously transferred from the Uncompensated Care Trust Fund;
4. any interest on monies in the Health Safety Net Trust Fund; and
5. any additional funding made available through appropriation or otherwise.

(b) Any amounts collected from sSurcharge pPayers in any fFiscal yYear in excess of the tTotal sSurcharge aAmount, adjusted to reflect applicable surcharge credits based on prior year collections, are transferred to the General Fund to support a portion of the costs of the MassHealth program.

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

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

(b) Shortfall Allocation. The Health Safety Net Office, using the best data available, estimates the projected total rReimbursable hHealth sServices provided by aAcute hHospitals and cCommunity hHealth cCenters; total Medical Hardship services; total bBad dDebt for eEmergency and uUrgent cCare sServices; and total Health Safety Net administrative expenses. If the Health Safety Net Office determines that, after adjusting for projected cCommunity hHealth cCenter payments and administrative expenses, Health Safety Net payments to aAcute hHospitals will exceed available funding, the Health Safety Net Office allocates the funding in a manner that reflects each aAcute hHospital's proportional fFinancial rRequirements for Health Safety Net payments through a graduated payment system. The Health Safety Net Office allocates the shortfall to dDisproportionate sShare hHospitals and other aAcute hHospitals as follows.

1. Disproportionate Share Hospital. The Health Safety Net Office determines dDisproportionate sShare hHospital status using data reported on the hHospital cCost rReport for the sSource yYear.

2. Allocation Method. The Health Safety Net Office allocates the shortfall as follows.

a. Determine the ratio of each aAcute hHospital's total pPatient care costs to the sum of all aAcute hHospitals' total pPatient care costs.

b. Multiply this ratio by the total sShortfall aAmount.

c. If calculated amount is greater than an aAcute hHospital's allowable Health Safety Net payments, then the shortfall allocation is limited to the aAcute hHospital's allowable Health Safety Net payments. If an aAcute hHospital's allowable Health Safety Net payment is a negative amount, then the shortfall allocation is limited to zero.

d. The Health Safety Net's gross liability to each aAcute hHospital is limited by the aAcute hHospital's allowable Health Safety Net payments less the sShortfall aAmount calculated in 101 CMR 614.03(2)(b)2.a. through c.

e. Each dDisproportionate sShare hHospital is paid the greater of

i. 85% of its allowable Health Safety Net payments; or

ii. the revised payment calculated according to the shortfall methodology in 101 CMR 614.03(2)(b)2.a. through e.

(c) Final Settlement. The Health Safety Net Office may implement a final settlement between the Health Safety Net and an aAcute hHospital for the fFiscal yYear. The final settlement is calculated based on the aAcute hHospital's gross liability to the Health Safety Net Trust Fund calculated pursuant to 101 CMR 614.04, the Health Safety Net's gross liability to the aAcute hHospital calculated pursuant to 101 CMR 614.06, and the payments made to the aAcute hHospital during the fFiscal yYear. The final settlement may occur when the Health Safety Net Office determines that it has sufficiently completed relevant claims adjudication and audit activity. For the purposes of the final settlement, the Health Safety Net Office may cease paying for claims that exceed the billing deadlines or other billing rules established at 101 CMR 613.00: *Health Safety Net Eligible Services*.

614.04: Acute Hospital and Non-acute Hospital Assessment Liability to the Health Safety Net Trust Fund

(1) Acute Hospital Assessment Calculation. Each aAcute hHospital's gross liability to the Health Safety Net Trust Fund is equal to the product of

(a) the ratio of its aAssessed cCharges to all aAcute hHospitals' aAssessed cCharges; and

(b) the tTotal aAcute hHospital aAssessment aAmount.

(2) Non-acute Hospital Assessment Calculation. Each Non-acute hHospital's gross liability to the Health Safety Net Trust Fund is equal to the product of

(a) the nNon-acute hHospital's aAssessed cCharges in that fFiscal yYear; and

(b) the ratio of the calculated acute hospital assessment in 101 CMR 614.04(1).

(3) Penalties for Non-payment.

(a) If an aAcute hHospital or nNon-acute hHospital does not pay the amount calculated pursuant to 101 CMR 614.04(1) or (2), respectively, or a specified portion thereof, by the due date established by the Health Safety Net Office, the Health Safety Net Office may assess up to a 3% penalty on the outstanding balance. The Health Safety Net Office will calculate the penalty on the outstanding balance as of the due date. The Health Safety Net Office may assess up to an additional 3% penalty against the outstanding balance and prior penalties for each month that a hHospital remains delinquent. The Health Safety Net Office will credit partial payments from delinquent hHospitals to the current outstanding liability. If any amount remains from the partial payment, the Health Safety Net Office will then credit such amount to the penalty amount.

(b) In determining the penalty amount, the Health Safety Net Office may consider factors including, but not be limited to, the hHospital's payment history, financial situation, and relative share of the payments.

614.05: Surcharge on Acute Hospital Payments

(1) General. There is a surcharge on certain payments to aAcute hHospitals and aAmbulatory sSurgical cCenters. The surcharge amount equals the product of payments

subject to surcharge as defined in 101 CMR 614.05(1)(b) and the sSurcharge pPercentage as defined in 101 CMR 614.05(2).

(a) Surcharge Payer.

1. A sSurcharge pPayer is an individual or entity that makes payments for the purchase of health care hHospital sServices and aAmbulatory sSurgical Ccenter Services, including a mManaged cCare oOrganization; provided, however, that the term "surcharge payer" does not include Title XVIII and Title XIX of the Social Security Act programs and their beneficiaries or recipients, except mManaged cCare oOrganizations; other governmental programs of public assistance and their beneficiaries or recipients; and the workers' compensation program established pursuant to M.G.L. c. 152.

2. The same entity that pays that aAcute hHospital or aAmbulatory sSurgical cCenter for services must pay the surcharge. If an entity such as a tThird pParty aAdministrator acts on behalf of a client plan and uses the client plan's funds to pay for the services, or advances funds to pay for the services for which it is reimbursed by the client plan, it must also act on behalf of the client plan and use the client plan's funds to pay the surcharge or advance funds to pay the surcharge for which it will be reimbursed by the client plan.

(b) Payments Subject to Surcharge. Payments subject to surcharge include

1. direct and indirect payments made by sSurcharge pPayers to Massachusetts aAcute hHospitals for the purchase of aAcute hHospital sServices and to Massachusetts aAmbulatory sSurgical cCenters for the purchase of aAmbulatory sSurgical cCenter sServices, with the following exceptions:

a. except for mManaged cCare oOrganization payments for MassHealth members and Commonwealth Care enrollees, the surcharge applies to all payments made on or after January 1, 1998, regardless of the date services were provided; and

b. for mManaged cCare oOrganization payments for MassHealth members 64 years of age or younger than 65 years old and for Commonwealth Care enrollees, the surcharge applies to all payments made on or after December 1, 2010, regardless of the date services were provided;

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

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

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

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

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

2. payments made on behalf of MassHealth members by MassHealth, Medicare beneficiaries by Medicare (including Medicare Advantage plans) except as provided in 101 CMR 614.05 (1)(b), persons enrolled in the Premium Assistance Payment Program Operated by the Health Connector, or persons enrolled in policies issued pursuant to M.G.L. c. 176K or similar policies issued on a group

basis, except that payments made by mManaged cCare oOrganizations on behalf of MassHealth members 64 years of age or younger than 65 years old who are not enrolled in an integrated care organization and Commonwealth Care enrollees are subject to surcharge;
3. payments made by an aAcute hHospital to a second aAcute hHospital for services that the first aAcute hHospital billed to a sSurcharge pPayer;
4. payments made by a group of pProviders, including one or more Massachusetts aAcute hHospitals or aAmbulatory sSurgical cCenters, to member aAcute hHospitals or aAmbulatory sSurgical cCenters for services that the group billed to an entity licensed or approved under M.G.L. chs. 175, 176A, 176B, 176G, or 176I;
5. payments made on behalf of an individual covered under the Federal Employees Health Benefits Act at 5 U.S.C. 8901 *et seq*.;
6. payments made on behalf of an individual covered under the workers' compensation program under M.G.L. c. 152; and
7. payments made on behalf of foreign embassy personnel who hold a Tax Exemption Card issued by the United States Department of State.

(d) The surcharge is distinct from any other amount paid by a sSurcharge pPayer for the services provided by an aAcute hHospital or aAmbulatory sSurgical cCenter. Surcharge amounts paid are deposited in the Health Safety Net Trust Fund.
(e) The Health Safety Net Office may issue additional guidance to clarify policies and understanding of substantive provisions of 101 CMR 614.05(1).

(2) Calculation of the Surcharge Percentage. The Health Safety Net Office uses the following methodology to calculate the percentage of the surcharge to be assessed on certain payments to aAcute hHospitals and aAmbulatory sSurgical cCenters, established in M.G.L. c. 118E, § 68. The Health Safety Net Office establishes the sSurcharge pPercentage before September 1st of each year, as follows.
(a) The Health Safety Net Office determines the total amount to be collected by adjusting the tTotal sSurcharge aAmount for any over or under collections from iInstitutional pPayers and individuals in previous years, including audit adjustments, as well as any over or under collections projected for October or November of the coming year.
(b) The Health Safety Net Office projects annual aggregate payments subject to the surcharge based on historical data, excluding projected annual aggregate payments made by mManaged cCare oOrganizations on behalf of MassHealth members and Commonwealth Care enrollees, with any adjustments the Health Safety Net Office deems necessary.
(c) The Health Safety Net Office divides the amount determined in 101 CMR 614.05(2)(a) by the amount determined in 101 CMR 614.05(2)(b).

(3) Payer Registration.
(a) Except for non-United States national insurers that have made fewer than ten payments per year in the prior three years to Massachusetts aAcute hHospitals and/or aAmbulatory sSurgical cCenters, all iInstitutional pPayers must register with the Health Safety Net Office by completing and submitting the Surcharge Payer Registration form. These payers must submit the registration form to the Health

Safety Net Office within 30 days after making a payment to any Massachusetts aAcute hHospital or aAmbulatory sSurgical cCenter.
(b) The Health Safety Net Office compiles lists of registered iInstitutional pPayers, and updates the lists quarterly. The Health Safety Net Office distributes these lists to aAcute hHospitals and aAmbulatory sSurgical cCenters upon request.
(c) Institutional pPayers must register only once, except that an iInstitutional pPayer that is also a mManaged cCare oOrganization must register separately as a mManaged cCare oOrganization. A registered payer is automatically registered for the next fFiscal yYear.

(4) Billing Process for Institutional Payers.
(a) Each aAcute hHospital and aAmbulatory sSurgical cCenter must send a bill for the Health Safety Net surcharge to sSurcharge pPayers, as required by M.G.L. c. 118E, § 68. Acute hHospitals and aAmbulatory sSurgical cCenters must send this bill to sSurcharge pPayers from whom they have received payment for services in the most recent four quarters for which data is available. The bill must state the sSurcharge pPercentage. Acute hHospitals and aAmbulatory sSurgical cCenters must send this bill to payers before September 1st of each fFiscal yYear and before the effective date of any sSurcharge pPercentage.
(b) Each aAcute hHospital and aAmbulatory sSurgical cCenter must also send a bill for the surcharge at the same time as the bill for services provided to iInstitutional pPayers who have not registered with the Health Safety Net Office pursuant to 101 CMR 614.05(3)(a) and from whom they have received payment. The bill must be sent within 30 days of receiving the payment from the unregistered payer. The bill must state the sSurcharge pPercentage, but not the dollar amount owed, and must include notification of the surcharge payment process set forth below, as well as a registration form specified by the Health Safety Net Office. Until the aAcute hHospital or aAmbulatory sSurgical cCenter receives the Registered Payer List, it must send a bill for the surcharge at the same time as the bill for services provided to iInstitutional pPayers that it did not already bill pursuant to 101 CMR 614.05(4)(a).

(5) Payment Process for Institutional Payers.
(a) Monthly Surcharge Liability. After the end of each calendar month, each iInstitutional pPayer must determine the surcharge amount it owes to the Health Safety Net Trust Fund for that month. The amount owed is the product of the amount of payments subject to surcharge, as defined in 101 CMR 614.05(1)(b), by the sSurcharge pPercentage in effect during that month. The iInstitutional pPayer may adjust the surcharge amount owed for any surcharge over- or under-payments in a previous period.
1. Institutional pPayers that pay a global fee or capitation for services that include aAcute hHospital or aAmbulatory sSurgical cCenter sServices, as well as other services not subject to the surcharge, must develop a reasonable method for allocating the portion of the payment intended to be used for services provided by aAcute hHospitals or aAmbulatory sSurgical cCenters. Such iInstitutional pPayers must file this allocation method by October 1st of each fFiscal yYear. If there is a significant change in the global fee or capitation payment arrangement that necessitates a change in the allocation method, the iInstitutional pPayer must

file the new method with the Health Safety Net Office before the new payment arrangement takes effect. Institutional p~~P~~ayers may not change the allocation method later in the year unless there is a significant change in the payment arrangement.

a. The Health Safety Net Office will review allocation plans within 90 days of receipt. During this review period the Health Safety Net Office may require an i~~I~~nstitutional p~~P~~ayer 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 a~~A~~cute h~~H~~ospitals or a~~A~~mbulatory s~~S~~urgical c~~C~~enters.

b. An i~~I~~nstitutional p~~P~~ayer must include the portion of the global payment or capitation intended to be used for services provided by a~~A~~cute h~~H~~ospitals or a~~A~~mbulatory s~~S~~urgical c~~C~~enters, as determined by this allocation method, in its determination of payments subject to surcharge.

2. An i~~I~~nstitutional p~~P~~ayer must include all payments made as a result of settlements, judgments, or audits in its determination of payments subject to surcharge. An i~~I~~nstitutional p~~P~~ayer may include payments made by Massachusetts a~~A~~cute h~~H~~ospitals or a~~A~~mbulatory s~~S~~urgical c~~C~~enters to the i~~I~~nstitutional p~~P~~ayer as a result of settlements, judgments, or audits as a credit in its determination of payments subject to surcharge.

(b) Monthly Payments. Institutional p~~P~~ayers must make payments to the Health Safety Net Trust Fund monthly. Each i~~I~~nstitutional p~~P~~ayer must remit the surcharge amount it owes to the Health Safety Net Trust Fund, determined pursuant to 101 CMR 614.05(5)(a), to the Health Safety Net Office for deposit in the Health Safety Net Trust Fund. Institutional p~~P~~ayers must remit the surcharge payment by the first business day of the second month following the month for which the surcharge amount was determined. For example, surcharge payments based on payments made to a~~A~~cute h~~H~~ospitals and a~~A~~mbulatory s~~S~~urgical c~~C~~enters in January are due by March 1st.

(c) Biannual Surcharge Payment Option.

1. An a~~A~~mbulatory s~~S~~urgical c~~C~~enter may request a biannual surcharge payment option if

a. it has remitted four or fewer payments during the previous f~~F~~iscal y~~Y~~ear;

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

c. it submitted a Surcharge Verification Form for the previous f~~F~~iscal y~~Y~~ear; and

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

2. The Health Safety Net Office notifies payers eligible for the biannual option. The Payer may elect to receive biannual surcharge notices or to continue to receive monthly notices. Each biannual surcharge payment equals the product of the appropriate surcharge percentage and all payments made by the payer to Massachusetts a~~A~~cute h~~H~~ospitals and a~~A~~mbulatory s~~S~~urgical c~~C~~enters for the prior six months.

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

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

(6) Payment Process for Individual Payers (Self-pay). There is a surcharge on certain payments made by iIndividual pPayers to aAcute hHospitals and aAmbulatory sSurgical cCenters.

(a) Billing.

1. Acute hHospitals and aAmbulatory sSurgical cCenters must include the surcharge amount on all bills to iIndividual pPayers unless

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

b. the pPatient is a non-Massachusetts resident for whom the aAcute hHospital or aAmbulatory sSurgical cCenter can verify that the pPatient's income would otherwise qualify the pPatient as a lLow--iIncome pPatient under 101 CMR 613.04: *Eligible Services to Low Income Patients*; or

c. the pPatient is approved for Medical Hardship in accordance with the requirements of 101 CMR 613.05: *Medical Hardship Services*. The bill must direct iIndividual pPayers to pay the surcharge to the aAcute hHospital or aAmbulatory sSurgical cCenter when making payment for services.

2. The amount of the surcharge billed is the product of the patient's liability to the aAcute hHospital or aAmbulatory sSurgical cCenter, and the sSurcharge pPercentage in effect on the billing date.

3. The amount of the surcharge owed by an iIndividual pPayer is the product of the total amount paid by the individual to an aAcute hHospital or aAmbulatory sSurgical cCenter and the sSurcharge pPercentage in effect on the payment date. Payments greater than or equal to the threshold received by aAcute hHospitals and aAmbulatory sSurgical cCenters from iIndividual sSurcharge pPayers are subject to the surcharge.

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

(c) Acute hHospitals and aAmbulatory sSurgical cCenters must remit such surcharge payments by the first business day of the second month following the month during which the surcharge was received. For example, surcharge payments received by aAcute hHospitals and aAmbulatory sSurgical cCenters in January are due to the

Health Safety Net Office on March 1st. Acute h~~H~~ospitals and a~~A~~mbulatory s~~S~~urgical c~~C~~enters may deduct collection agency fees for the collection of surcharge payments from i~~I~~ndividual p~~P~~ayers from the total amount of surcharge payments forwarded to the Health Safety Net Office.

(d) All payments must be payable in United States dollars and drawn on a United States bank. The Health Safety Net Office assesses a $30.00 penalty on any s~~S~~urcharge p~~P~~ayer whose check is returned for insufficient funds.

(e) If an embassy of a foreign government pays an a~~A~~cute h~~H~~ospital or a~~A~~mbulatory s~~S~~urgical c~~C~~enter bill on behalf of an individual, the p~~P~~rovider may either bill the embassy for the individual's surcharge according to the billing and payment process for i~~I~~ndividual p~~P~~ayers set forth in 101 CMR 614.05(6) or bill the embassy according to the billing process for i~~I~~nstitutional p~~P~~ayers as set forth in 101 CMR 614.05(4). If the p~~P~~rovider chooses to bill the embassy as an i~~I~~nstitutional p~~P~~ayer and the embassy is not listed on the Registered Payer List, the p~~P~~rovider must include the embassy on the Unmatched Payer Report and send surcharge payer registration information to the embassy.

(7) Penalties. If an a~~A~~cute h~~H~~ospital, a~~A~~mbulatory s~~S~~urgical c~~C~~enter, or s~~S~~urcharge p~~P~~ayer fails to forward surcharge payments pursuant to 101 CMR 614.05, the Health Safety Net Office imposes an additional 1.5% interest penalty on the outstanding balance. The interest is calculated from the due date. For each month a payment remains delinquent, an additional 1.5% penalty accrues against the outstanding balance, including prior penalties.

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

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

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

(a) The Health Safety Net Office reviews data submitted by a~~A~~cute h~~H~~ospitals, a~~A~~mbulatory s~~S~~urgical c~~C~~enters, and i~~I~~nstitutional p~~P~~ayers pursuant to 101 CMR 614.08, the Surcharge Payer Registration forms submitted by i~~I~~nstitutional p~~P~~ayers pursuant to 101 CMR 614.05(3)(a), and any other pertinent data. All information provided by, or required from, any s~~S~~urcharge p~~P~~ayer, pursuant to 101 CMR 614.00 is subject to audit by the Health Safety Net Office. For surcharge payments based upon a global fee or capitation allocated according to an allocation method accepted by the Health Safety Net Office pursuant to 101 CMR 614.05(5)(a)1., the Health Safety Net Office's review is limited to determining whether this method was followed accurately and whether the amounts reported were accurate.

(b) The Health Safety Net Office may require the s~~S~~urcharge p~~P~~ayer to submit additional documentation reconciling the data it submitted with data received from a~~A~~cute h~~H~~ospitals.

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

(d) Processing of Payment Adjustments.

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

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

a. each adjustment to which the s~~S~~urcharge p~~P~~ayer is objecting;
b. the f~~F~~iscal y~~Y~~ear for each disputed adjustment;
c. the specific reason for each objection; and
d. all documentation that supports the s~~S~~urcharge p~~P~~ayer's position.

3. Upon review of the s~~S~~urcharge p~~P~~ayer's objections, the Health Safety Net Office notifies the s~~S~~urcharge p~~P~~ayer of its determination in writing. If the Health Safety Net Office disagrees with the s~~S~~urcharge p~~P~~ayer's objections, in whole or in part, the Health Safety Net Office provides the s~~S~~urcharge p~~P~~ayer with an explanation of its reasoning.

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

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

614.06: Payments to Acute Hospitals

(1) General Provisions.

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

(b) Payment Types.

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 614.00: HEALTH SAFETY NET PAYMENTS AND FUNDING

1. The Health Safety Net Office calculates Health Safety Net payments for each aAcute hHospital for the following categories of claims for which the Health Safety Net is the primary payer:
   a. Inpatient - Medical (under 101 CMR 614.06(2)(a) and (b));
   b. Inpatient - Psychiatric (under 101 CMR 614.06(2)(c));
   c. Inpatient - Rehabilitation (under 101 CMR 614.06(2)(d));
   d. Outpatient Services (under 101 CMR 614.06(3));
   e. Physician Services (under 101 CMR 614.06(4));
   f. Dental Services (under 101 CMR 614.06(5));
   g. Acute Hospital Outpatient Pharmacies (under 101 CMR 614.06(6));
   h. Vaccine Administration (under 101 CMR 614.06(7));
   i. Emergency Bad Debt - Inpatient Medical (under 101 CMR 614.06(9));
   j. Emergency Bad Debt - Inpatient Psychiatric (under 101 CMR 614.06(9));
   k. Emergency Bad Debt - Outpatient (under 101 CMR 614.06(9)); and
   l. Medical Hardship (under 101 CMR 614.06(10)).
2. Under 614.06(8), the Health Safety Net Office establishes payments for claims which the Health Safety Net is the secondary payer.
3. The Health Safety Net Office reduces payments by the amount of eEmergency bBad dDebt recoveries and investment income on free care endowment funds. The Health Safety Net Office determines the offset of free care endowment funds by allocating free care endowment income between Massachusetts residents and nonresidents using the best data available and offsetting the Massachusetts portion against Health Safety Net claims.

(c) Method of Payment. The Health Safety Net may make payments to aAcute hHospitals for eEligible sServices through a safety net care payment under the Massachusetts Section 1115 Demonstration Waiver, a MassHealth supplemental aAcute hHospital rate payment, or a combination thereof. The Health Safety Net Office may limit an aAcute hHospital's payment for eEligible sServices to comply with requirements under the Massachusetts Section 1115 Demonstration Waiver governing safety net care, including cost limits or any other federally required limit on payments under 42 U.S.C. § 1396a(a)(13) or 42 CFR 447.
(d) Provider Preventable Conditions. The Health Safety Net does not pay for services related to pProvider pPreventable cConditions defined in 42 CFR 447.26. The Health Safety Net Office may issue administrative bulletins clarifying billing requirements and payment specifications for pProvider pPreventable cConditions.

(2) Pricing for Inpatient Services. The Health Safety Net Office prices aAcute hHospital claims in accordance with the Medicare Inpatient Prospective Payment System (IPPS) for non-psychiatric claims and the Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS) for psychiatric claims for the current fFiscal yYear. Medicare pricing data is published in the *Federal Register* and pricing methodologies are described in 42 CFR 412. Claims from aAcute hHospitals classified by Medicare as cCritical aAccess hHospitals (CAHs), PPS-exempt hHospitals, Medicare--dDependent rRural hHospitals, and sSole cCommunity hHospitals are priced in accordance with 101 CMR 614.06(2)(b).

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

(b) Inpatient Medical Pricing - Other Acute Hospitals.

1. Critical Access Hospitals and PPS-exempt Hospitals. The Health Safety Net Office calculates a per discharge payment for discharges occurring at Medicare c~~C~~ritical a~~A~~ccess h~~H~~ospitals and PPS-exempt cancer and p~~P~~ediatric h~~H~~ospitals as follows.

a. The Health Safety Net Office determines the average charge per discharge using adjudicated and eligible Health Safety Net claims data from the s~~S~~ource y~~Y~~ear that is available at the time of rate calculation.

b. The Health Safety Net Office determines an average cost per discharge by multiplying the average charge per discharge by an inpatient cost to charge ratio using data as reported on the h~~H~~ospital c~~C~~ost r~~R~~eport for the s~~S~~ource y~~Y~~ear.

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

d. If the a~~A~~cute h~~H~~ospital has fewer than 20 discharges in the s~~S~~ource y~~Y~~ear, the Health Safety Net Office sets a payment on account factor for the a~~A~~cute h~~H~~ospital.

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

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

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

(c) Inpatient Psychiatric Pricing.

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

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

(d) Inpatient Rehabilitation Pricing.

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

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

(e) Hospital-acquired Conditions.

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

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

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

(g) Administrative Days. The Health Safety Net pays aAdministrative dDays at the *per diem* rate established by MassHealth pursuant to the aAcute hHospital Request for Applications for the current fFiscal yYear when the Health Safety Net is the

primary payer. When the Health Safety Net is not the primary payer, a~~A~~dministrative d~~D~~ays are paid per 101 CMR 614.06(8).

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

(a) For each a~~A~~cute h~~H~~ospital, the Health Safety Net Office calculates an average outpatient charge per visit, using such adjudicated and eligible Health Safety Net claims data from the s~~S~~ource y~~Y~~ear as of June 15, 2016. Charges for dental claims, charges for claims that are $20.00 or below, and charges for outpatient claims within 72 hours of an inpatient admission are excluded. For c~~C~~ritical a~~A~~ccess h~~H~~ospitals and PPS-exempt h~~H~~ospitals, only charges for claims within 24 hours of an inpatient admission are excluded.

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

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

(d) Disproportionate s~~S~~hare h~~H~~ospitals and non-teaching a~~A~~cute h~~H~~ospitals receive a transitional add-on of 25% of the outpatient per visit payment rate.

(e) The per visit payments for PPS-exempt cancer and p~~P~~ediatric h~~H~~ospitals and Medicare c~~C~~ritical a~~A~~ccess h~~H~~ospitals are determined using the ratio of costs to charges as reported on the h~~H~~ospital c~~C~~ost r~~R~~eport for the s~~S~~ource y~~Y~~ear rather than the Medicare PAF ~~payment on account factor~~ data.

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

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

(5) Dental Services. The Health Safety Net Office prices claims from a~~A~~cute h~~H~~ospitals for outpatient dental services provided at a~~A~~cute h~~H~~ospitals and h~~H~~ospital l~~L~~icensed h~~H~~ealth c~~C~~enters using the lesser of the allowable charges billed to the HSN, or the fees established in 101 CMR 314.00: *Dental Services*. No additional outpatient per visit payment is paid for dental services.

(6) Acute Hospital Outpatient Pharmacies.

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

(b) Part B Covered Services. Medical supplies normally covered by the Medicare Part B program that are dispensed by a~~A~~cute h~~H~~ospital outpatient pharmacies that are not Part B p~~P~~roviders are priced at 20% of the rates set forth in ~~114.3~~101 CMR 322.00: *Durable Medical Equipment, Oxygen, and Respiratory Therapy Equipment* and 101 CMR 331.00: *Prescribed Drugs*.

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

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

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

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

(c) MassHealth as Primary Payer. Health Safety Net pays allowable claims with MassHealth as the primary payer in accordance with 101 CMR 613.03(1)(c).~~-~~The payment is the product of the ~~net of~~ reimbursable charges for services listed in 101 CMR 613.03(3) that are not covered by MassHealth and the Medicare PAF as defined in 101 CMR 614.06(3)(b). Payment will not exceed the amount the Health Safety Net Office would have paid if it were the primary payer.

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

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

(9) Bad Debt Pricing. Except as provided at 101 CMR 614.06(9)(a), the Health Safety Net Office calculates e~~E~~mergency b~~B~~ad d~~D~~ebt payments for inpatient, psychiatric, and outpatient e~~E~~ligible s~~S~~ervices, using the methodology in 101 CMR 614.06(2) and (3),

except that the e~~E~~mergency b~~B~~ad d~~D~~ebt outpatient rate does not include the transitional add-on cited in 101 CMR 614.06(3)(d).

(a) If an a~~A~~cute h~~H~~ospital has fewer than 20 e~~E~~mergency b~~B~~ad d~~D~~ebt claims during the s~~S~~ource y~~Y~~ear, the Health Safety Net Office sets the e~~E~~mergency b~~B~~ad d~~D~~ebt rate as the outpatient primary per visit rate established in 101 CMR 614.06(3), excluding the transitional add-on under 101 CMR 614.06(3)(d).

(b) The Health Safety Net Office pays h~~H~~ospital l~~L~~icensed h~~H~~ealth c~~C~~enters 75% of the PPS r~~R~~ate as published by Medicare for b~~B~~ad d~~D~~ebt claims for u~~U~~rgent c~~C~~are s~~S~~ervices that meet the requirements in 101 CMR 613.00: *Health Safety Net Eligible Services*.

(10) Medical Hardship. The Health Safety Net pays for claims for p~~P~~atients deemed eligible for Medical Hardship pursuant to 101 CMR 613.00: *Health Safety Net Eligible Services*.

(a) The Health Safety Net pays the claim as if it were a primary Health Safety Net claim if there are no other primary payers on the claim.

(b) If the billed claim has a primary payer, the claim is paid as a secondary claim in accordance with the provisions of 101 CMR 614.06(8).

(c) The Health Safety Net Office reduces the amount paid by ~~of the billed charges by any third-party payments, third-party contractual discounts, Patient payments, and~~ the amount of the Medical Hardship contribution, if applicable. ~~If the adjusted charges are less than the total claim charges, the claim is paid as a secondary claim in accordance with the provisions of 101 CMR 614.06(8). If the billed charges are not reduced, the Health Safety Net pays the claim as if it were a primary Health Safety Net claim.~~

(11) Other. The Health Safety Net makes an additional payment of $3.85 million to freestanding p~~P~~ediatric h~~H~~ospitals with more than 1,000 Medicaid discharges during the s~~S~~ource y~~Y~~ear for which a standard payment amount per discharge was paid by MassHealth pursuant to the a~~A~~cute h~~H~~ospital Request for Applications, as determined by paid claims in the Medicaid Management Information System as of June 15, 2016, and for which MassHealth was the primary payer. The Health Safety Net may make an additional payment adjustment for the two d~~D~~isproportionate s~~S~~hare h~~H~~ospitals with the highest relative volume of free care costs in FY2006.

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

614.07: Payments to Community Health Centers

(1) General Provisions.

(a) The Health Safety Net pays c~~C~~ommunity h~~H~~ealth c~~C~~enters based on claims submitted to the Health Safety Net Office, less applicable cost sharing amount, in

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

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

(2) Payments for Services.

(a) The Health Safety Net will pay cCommunity hHealth cCenters a Medicare-based rate per pPatient per day for rReimbursable hHealth sServices unless otherwise specified by the table belowin 101 CMR 614.07(2)(c). Payment will be either the PPS rRate, or the total charges applicable under the PPS rRate for services furnished, whichever is less. The PPS rRate will be adjusted for geographic differences in the cost of services based on the Medicare FQHC PPS gGeographic aAdjustment fFactors. In addition, the PPS rRate will be increased according to 42 CFR 405.2464(b)(2)7 when a cCommunity hHealth cCenter furnishes care to a pPatient that is new to the cCommunity hHealth cCenter or to a pPatient receiving a comprehensive initial visit or an annual wellness visit.

(b) The PPS rRate applies to iIndividual mMedical vVisits, mental health visits, surgical procedures, behavioral health diagnostic and treatment services, diagnostic vision care, medical nutrition therapy, diabetes self-management treatment, and tobacco cessation services. Only one visit per pPatient per day can be billed, with the following exceptions: of

1. when a mental health visit occurs on the same day as a medical visit; or.

2. when an illness or injury necessitating a visit occurs on the same day as another visit.

(c) For rReimbursable hHealth sServices not included in the PPS rRate, the Health Safety Net pays cCommunity hHealth cCenters according to the following table, except for claims for bBad dDebt for uUrgent cCare sServices. Payments are based on regulations named. Some rReimbursable hHealth sServices under 101 CMR 614.07(2) may be listed as individual consideration in the regulations named. For individual consideration codes billable to the Health Safety Net, the payment rate is calculated as (total payments made to cCommunity hHealth cCenters by MassHealth for the code) / (total number of claims paid by MassHealth for the code) during the sSource yYear. If MassHealth payment and claims information for a code is not available for sSource yYear, the rate for the code will be based on Medicare fee schedules or other relevant sources. The Health Safety Net pays only for services listed in the HSN CHC Billable Procedure Codes list.

Type of Service	Payment Rules	Payment Source
Medical Visit – Urgent Care (code 99051)	Payable separately from an Individual Medical Visit.	Rate for 99050 in 101 CMR 304.00: *Rates for Community Health Centers*
Pulmonary Diagnostic	Payable separately only if not	101 CMR 317.00:

Type of Service	Payment Rules	Payment Source
(technical component only)	occurring on the same day as an Individual Medical Visit.	*Medicine*
Cardiology Diagnostic (technical component only)	Payable separately from an Individual mMedical vVisit.	101 CMR 317.00: *Medicine*
Obstetrical Services	Payable separately from an iIndividual mMedical vVisit	101 CMR 316.00: *Surgery and Anesthesia Services*
Behavioral Health (group treatment, environmental intervention, crisis intervention, medication management, psychological testing, developmental screening, and methadone services)	Payable separately from an iIndividual mMedical vVisit.	For group treatment, environmental intervention, crisis intervention, and medication visits, rates in 101 CMR 306.00: *Rates of Payment for Mental Health Services Provided in Community Health Centers and Mental Health Centers*; for psychological testing, rates in 114.3 CMR 29.00: *Psychological Services*; for developmental screening, rates in 101 CMR 317.00: *Medicine;* for methadone services, rates in 101 CMR 346.00: *Rates for Certain Substance-related and Addictive -Disorders Programs*
Radiology	Payable separately from an iIndividual mMedical vVisit.	101 CMR 318.00: *Radiology*
Clinical Laboratory	Payable separately from an iIndividual mMedical vVisit.	101 CMR 320.00: *Clinical Laboratory Services*
Dental	Payable separately from an iIndividual mMedical vVisit.	Lesser of allowable charges billed to the HSN, or fees established in 101 CMR 314.00: *Dental Services*
340B Pharmacy Services	Payment will be reduced by the amount of pPatient cost-sharing set forth in 101 CMR 613.00: *Health Safety Net Eligible Services*.	101 CMR 331.00: *Prescribed Drugs*
Vision Care (dispensing and repair)	Payable separately from an iIndividual mMedical vVisit.	101 CMR 315.00: *Vision Care Services and Ophthalmic Materials*
Family Planning Services	Family planning counseling, prescribed drugs, family planning supplies, and related laboratory	101 CMR 312.00: *Family Planning Services*

Type of Service	Payment Rules	Payment Source
	tests can be billed in addition to an iIndividual mMedical vVisit. An iIndividual mMedical vVisit is not payable for the sole purpose of replenishing a pPatient's supply of contraceptives.	
Preventive Services/Risk Factor Reduction (code 99402)	Payable separately from an iIndividual mMedical vVisit.	101 CMR 312.00: *Family Planning Services*
Immunization Visits	Payable separately only if not occurring on the same day as an iIndividual mMedical vVisit.	101 CMR 317.00: *Medicine*
Vaccines Not Included in the Individual Medical Visit or Supplied by the Department of Public Health	Payable separately from an iIndividual mMedical vVisit.	101 CMR 317.00: *Medicine*

(3) Bad Debt Payments for Urgent Care Services. The Health Safety Net pays cCommunity hHealth cCenters at 75% of the payment rates in 101 CMR 614.07(2) for bBad dDebt claims for uUrgent cCare sServices that meet the requirements in 101 CMR 613.00: *Health Safety Net Eligible Services.*

(4) Secondary Payer. The Health Safety Net pays claims to community health centers for which it is not the primary payer as follows.

(a) 95% Rule. If a claim billed to the Health Safety Net has a ratio of total billed net charges to total claim charges that is greater than 95%, the Health Safety Net pays the claim in accordance with the applicable primary payment rules listed in 101 CMR 614.07(2).

(b) Other Secondary Claims. For all other secondary claims, the Health Safety Net pays the lesser of the amount under the applicable primary payment rules detailed in 101 CMR 614.07(2) or the total of the allowable patient responsibility and the reimbursable health services not covered by the primary payer, in accordance with the provisions of 101 CMR 613.03(1)(c).

(5) Medical Hardship. The Health Safety Net pays for claims for patients deemed eligible for Medical Hardship pursuant to 101 CMR 613.00: *Health Safety Net Eligible Services.*

(a) The Health Safety Net pays the claim as if it were a primary Health Safety Net claim if there are no other primary payers on the claim.

(b) If the billed claim has a primary payer, the claim is paid as a secondary claim in accordance with the provisions of 101 CMR 614.07(4).

(c) The Health Safety Net Office reduces the amount paid by the amount of the Medical Hardship contribution, if applicable.

614.08: Reporting Requirements

101 CMR: EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

101 CMR 614.00: HEALTH SAFETY NET PAYMENTS AND FUNDING

(1) General. Each p~~P~~rovider, s~~S~~urcharge p~~P~~ayer, and a~~A~~mbulatory s~~S~~urgical c~~C~~enter must file with or make available to the Health Safety Net Office or to an entity designated by the Health Safety Net Office to collect data, as applicable, information that is required or that the Health Safety Net Office deems reasonably necessary for implementation of 101 CMR 614.00.

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

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

(2) Acute Hospitals.

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

(b) Surcharge Payment Data.

1. Unmatched Payer Report. Each a~~A~~cute h~~H~~ospital must submit to the Health Safety Net Office a quarterly Unmatched Payer Report. The a~~A~~cute h~~H~~ospital must report the total amount of payments for services received from each i~~I~~nstitutional p~~P~~ayer that does not appear on the Registered Payer List. The a~~A~~cute h~~H~~ospital must report these data in an electronic format specified by the Health Safety Net Office.

2. Quarterly Report for Private Sector Payments. Each a~~A~~cute h~~H~~ospital must report to the Health Safety Net Office total payments made by the largest i~~I~~nstitutional s~~S~~urcharge p~~P~~ayers. The Health Safety Net Office specifies the i~~I~~nstitutional payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Health Safety Net Office may modify the reporting requirements by administrative bulletin.

(c) Penalties. The Health Safety Net Office may deny payment for e~~E~~ligible s~~S~~ervices to any a~~A~~cute h~~H~~ospital that fails to comply with the reporting requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* or 614.00 until such a~~A~~cute h~~H~~ospital complies with the requirements. The Health Safety Net Office notifies such a~~A~~cute h~~H~~ospital in advance of its intention to withhold payment.

(3) Community Health Centers. The Health Safety Net Office may deny payment for e~~E~~ligible s~~S~~ervices to any c~~C~~ommunity h~~H~~ealth c~~C~~enter that fails to comply with the reporting requirements of 101 CMR 613.00: *Health Safety Net Eligible Services* or 614.00 until such c~~C~~ommunity h~~H~~ealth c~~C~~enter complies with the requirements. The

Health Safety Net Office notifies such c~~C~~ommunity h~~H~~ealth c~~C~~enter in advance of its intention to withhold payment.

(4) Surcharge Payers.

(a) Monthly Surcharge Payment Report. The Health Safety Net Office may require that an i~~I~~nstitutional p~~P~~ayer submit to the Health Safety Net Office monthly reports of payments to a~~A~~cute h~~H~~ospitals and a~~A~~mbulatory s~~S~~urgical c~~C~~enters.

(b) Third Party Administrators. A t~~T~~hird p~~P~~arty a~~A~~dministrator s~~S~~urcharge p~~P~~ayer that makes payments to a~~A~~cute h~~H~~ospitals and a~~A~~mbulatory s~~S~~urgical c~~C~~enters on behalf of one or more insurance carriers must file an annual report with the Health Safety Net Office. The report must include the name of each insurance carrier for which it makes surcharge payments. The Health Safety Net Office may also specify additional reporting requirements concerning payments made on behalf of self-insured plans. Reports must be in an electronic format specified by the Health Safety Net Office. Said reports must be filed by July 1st of each year for the time period requested by the Health Safety Net Office.

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

(5) Ambulatory Surgical Centers.

(a) Unmatched Payer Report. Each a~~A~~mbulatory s~~S~~urgical c~~C~~enter must submit a quarterly Unmatched Payer Report to the Health Safety Net Office in accordance with a schedule specified by the Health Safety Net Office. The a~~A~~mbulatory s~~S~~urgical c~~C~~enter must report the total amount of payments for services received from each i~~I~~nstitutional s~~S~~urcharge p~~P~~ayer that does not appear on the Registered Payer List. The a~~A~~mbulatory s~~S~~urgical c~~C~~enter must report these data in an electronic format specified by the Health Safety Net Office.

(b) Quarterly Report for Private Sector Payments. Each a~~A~~mbulatory s~~S~~urgical c~~C~~enter must report to the Health Safety Net Office total payments made by the largest i~~I~~nstitutional s~~S~~urcharge p~~P~~ayers. The Health Safety Net Office specifies the i~~I~~nstitutional p~~P~~ayers for which reporting is required, the periods for which reporting is required, and the reporting format. The Health Safety Net Office may modify the reporting requirements by administrative bulletin.

614.09: Special Provisions

(1) Financial Hardship. An a~~A~~cute h~~H~~ospital or s~~S~~urcharge p~~P~~ayer may request a deferment or partial payment schedule due to financial hardship.

(a) In order to qualify for such relief, the a~~A~~cute h~~H~~ospital or s~~S~~urcharge p~~P~~ayer must demonstrate that its ability to continue as a financially viable going concern will be seriously impaired if payments pursuant to 101 CMR 614.04 or 614.05 were made.

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

1. The interest rate used for the payment schedule does not exceed the prime rate plus 2%. The prime rate used is the rate reported in the *Wall Street Journal* dated the last business day of the month preceding the establishment of the payment schedule.

2. A sSurcharge pPayer may make a full or partial payment of its outstanding liability at any time without penalty.

3. If a sSurcharge pPayer fails to meet the obligations of the payment schedule, the Health Safety Net Office may assess penalties pursuant to 101 CMR 614.05.

(2) Ordering, Referring, and Prescribing Provider Requirements.

(a) In order to be payable, any claim to the Health Safety Net for a type of reimbursable health service for which the MassHealth program requires an order, referral or prescription, must include the National Provider Identifier (NPI) of a MassHealth participating authorized ordering, referring, or prescribing provider.

(b) Acute hospitals and community health centers must comply with any formal written issuances of the MassHealth agency and Health Safety Net Office regarding ordering, referring and prescribing requirements.

~~(3) Provider Participation. If the NPI of a provider who is not a MassHealth participating provider is included on a Health Safety Net claim for any, that claim may not be payable.~~

(342) Severability. The provisions of 101 CMR 614.00 are severable. If any provision or the application of any provision to any aAcute hHospital, cCommunity hHealth cCenter, surcharge payer, or aAmbulatory sSurgical cCenter or circumstances is held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 614.00 or the application of such provisions to aAcute hHospitals, cCommunity hHealth cCenters, or circumstances other than those held invalid.

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

REGULATORY AUTHORITY

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