104 CMR 30.00: FISCAL ADMINISTRATION

Section

30.01: Patient Funds in Facilities.

(1) Authority. 104 CMR 30.01 is promulgated pursuant to M.G.L. c. 123, §§ 2, 4, 25, and 26(a).

(2) Scope. 104 CMR 30.01 shall apply to Department facilities and inpatient units contracted for by the Department. It shall apply to the maintenance and expenditure of patient funds which are located within the facility or which are deposited with the facility director or his or her designee. For purpose of this regulation any reference to facility shall include a Department contracted inpatient unit.

(3) Definitions. In addition to the terms defined in 104 CMR 25.02: *Definitions*, the following terms shall have the meanings set forth in this section throughout 104 CMR 30.01, unless the content clearly provides otherwise.

Dependent Funds mean those funds belonging to a patient that are located at a facility or received by a facility if:

(a). the patient is unable to manage these funds himself or herself as determined by an evaluation in accordance with 104 CMR 30.01(5);

(b). the patient is unable to manage these funds as determined by a court of competent jurisdiction;

(c). the patient is unable to manage these funds as determined by the Social Security Administration or Veterans Administration in accordance with their requirements;

(d). the funds were received from a legally authorized representative of the patient for the patient; or

(e). the funds belong to a patient who is a minor.

Funds mean cash, checks, negotiable instruments, or other income or liquid assets.

Independent Funds mean all of a patient's funds which are located at the facility and which are not dependent funds.

Liquid Assets means cash and all property capable of ready conversion into cash whether held jointly or solely. Liquid assets do not include life insurance or its cash value, nor assets subject to an irrevocable trust with the patient or client as named beneficiary, unless those assets are available to the patient or client or fee payer on demand.

(4) Upon Admission and Prior to Evaluation. All of a patient's funds shall be deemed to be independent funds, unless such funds have been determined to be dependent as defined in 104 CMR 30.01(3).

(5) Evaluation of Ability to Manage Funds.

(a) Unless a legally authorized representative has been appointed with authority to manage all of the patient's funds, or the patient is a minor, the clinical staff of the facility shall evaluate the patient as soon as possible after admission (but no later than 30 days after admission); at least once during the second three months after admission; and at least every 12 months thereafter; or upon the patient's request, to determine his or her ability to manage and spend his or her funds. No patient shall be found unable to manage and spend his or her funds unless it is determined by a clinical evaluation that the patient is unable to manage and spend money to satisfy his or her needs and desires because:

1. he or she lacks a basic understanding of the value of money; or

2. his or her fiscal judgment is significantly impaired due to delusional thinking or due to a lack of appreciation of his or her needs and desires, as shown by actual past example or by strong medical evidence.

The evaluation shall be pursuant to any guidelines established by the Department. The evaluation shall be a part of the periodic review of the patient pursuant to M.G.L. c. 123, § 4 and 104 CMR 27.11: *Periodic Review*.

(b) The evaluation shall take into consideration the amount of the patient's present and future funds and determine:

1. whether the patient is able to manage and spend all of his or her funds;
2. if the patient is not able to manage and spend all of his or her funds, how much of such funds he or she is able to manage and spend and how much of such funds he or she is not able to manage and spend; and
3. in regard to funds the patient is not able to manage and spend himself or herself, how such funds can best be used to benefit the patient, consistent with 104 CMR 30.01(9).

(c) The results of the evaluation shall become part of the patient's record and a copy shall be provided to the patient and his or her legally authorized representative, if any.

(d) At least seven days prior to the evaluation, the patient shall receive both written and oral notice of the evaluation which includes a description of the evaluation process. At the evaluation, the patient shall have the right to present any information on his or her behalf, and to be assisted by a person of his or her choice. The patient shall be informed that the facility's Human Rights Officer is available to assist him or her. In addition, the patient shall be informed of the right to seek legal assistance. The facility director or his or her designee, may waive the requirement of seven days written and oral notice to the patient of such evaluations only pursuant to the provisions of 104 CMR 30.01(5)(e).

(e) Emergency Evaluation. Facilities shall have procedures for situations where a patient's use of his or her funds present a significant risk to the patient, others, or the funds themselves. These procedures may include an emergency evaluation of the patient's ability to manage his or her funds by the facility's clinical staff, without prior notice as described in 104 CMR 30.01(5)(d) if the circumstances so require. The reasons for any such emergency evaluations shall be explained to the patient at the time of the evaluation and shall be documented in the patient's record. In addition, within 14 days of an emergency evaluation, the patient must be given another evaluation of his or her ability to manage funds with the notices and other protections described in 104 CMR 30.01(5)(d). Funds which are determined at an emergency evaluation to be dependent funds may be spent by the facility director only with the approval of the patient or his or her legally authorized representative, if any.

(6) Evaluation of Need for a Legally Authorized Representative.

(a) If a patient is determined to be unable to manage his or her funds, pursuant to 104 CMR 30.01(5), a further determination shall be done as to whether or not the appointment of a legally authorized representative to manage the patient's funds is indicated and if so, the type of legally authorized representative that is needed. The determination and the reason(s) for it shall be documented in the patient's record.

(b) If a determination is made that a legally authorized representative is needed, or if in accordance with M.G.L. c. 123, § 25, a patient has been under the care of the Department for at least six months and it has been determined pursuant to 104 CMR 30.01(5) that the patient is not able to manage and spend any of his or her funds independently and the patient does not have a legally authorized representative, the Department shall notify the patient and the patient's nearest living relative to recommend that the necessary steps be taken to appoint an appropriate legally authorized representative.

(7) Training Patients to Manage Their Own Funds. A patient's treatment team shall develop a plan to teach or assist the patient to manage all, or a portion, of his or her own funds according to his or her capabilities and the level of supports available to him or her.

(8) Use of Independent Funds by the Patient. The patient shall have an unrestricted right to manage and spend, at his or her sole discretion, all of his or her independent funds. Independent funds, at the patient's discretion, may be deposited with the facility director or his or her designee.

(9) Management and Expenditure of Dependent Funds.

(a) Facility Director. In accordance with M.G.L. c. 123, § 26(a) and federal regulations, the facility director shall bear ultimate responsibility for the management and expenditure of all dependent funds.

(b) Designated Staff. To carry out his or her responsibility as to the proper management and expenditure of dependent funds, the facility director shall designate staff within the facility who shall be directly responsible to the facility director and who shall determine on a day-to-day basis how to best manage and spend a patient's dependent funds, consistent with 104 CMR 30.01(9). These designated staff shall have sufficient contact with the patient to have firsthand knowledge of the patient and to be responsive to the patient's day-to-day needs and desires. Designated staff shall consult with a patient prior to making a purchase for him or her. The facility director may establish a committee to make recommendations regarding the expenditure of dependent funds.

(c) Appropriate Expenditures. Dependent funds shall be used only for purposes which directly benefit the patient. Generally, dependent funds should be used to facilitate the patient's earliest possible rehabilitation and discharge to the community, for personal needs to improve the patient's condition while in the facility, and to help the patient live as normal and comfortable a life as practicable. The patient's desires, as well as needs, will be considered. Where the patient has unmet current needs, continued saving of dependent funds is not in the patient's interest unless such saving is for a foreseeable and appropriate future purpose such as to pay for living expenses upon discharge. A patient's current needs include paying the facility's charge for care of the patient, as determined in accordance with 104 CMR 30.04 and other applicable law. Dependent funds shall not be expended for any item or service which the facility is obligated to supply the patient and which would already have been included with the usual and customary charge for care or which the patient is otherwise entitled to receive without charge.

(d) Group Purchases. Dependent funds of a patient may be used together with funds of other patients to allow for a group purchase. However, a group purchase may be made only if all patients in the group shall benefit from such purchase, and contribute a fair amount to the purchase. Patients and their legally authorized representatives, if any, should be consulted prior to any such group purchase.

(10) Maintenance of Bank Accounts; Records and Accountings.

(a) Pursuant to M.G.L. c. 123, § 26(a), the facility director or his or her designee may maintain individual bank accounts on behalf of the facility's patients. These accounts shall be interest bearing accounts if commercially available and fiscally prudent. Interest

earned in any such account shall be credited to the patient. Alternatively, the facility may deposit up to a set amount, established by the Department by policy, of a patient's funds in a group bank account so long as an individual record is maintained of each patient's deposits and withdrawals, and interest is appropriately apportioned among the patients in the group.

(b) The facility must have written policies and procedures concerning internal controls and accounting procedures for the management of patient funds on deposit with the facility.

(c) The financial manager of the facility must file an annual report with the Deputy Commissioner of Administration and Finance, or designee, listing all group accounts and individual bank accounts that were maintained by the facility during the year. The report shall include the beginning and ending balances of each account. Each annual report shall be in the form and manner prescribed by the Deputy Commissioner of Administration and Finance.

(d) Record of Funds. All funds received from a patient or received on his or her behalf shall be accounted for, and a record made showing the amount of funds received, date received and source of the funds. Additionally all funds disbursed shall be accounted for, and a record made showing the amount of funds disbursed, date disbursed, reason for disbursement and to whom funds were disbursed.

(e) Accounting for Funds. The following persons shall, upon their request, be provided a complete written account of all funds of a patient, or, if requested, a written or oral statement of the current balance of funds of the patient:

1. the patient;
2. if the patient is determined unable to manage or spend all or part of his or her funds, the staff designated as responsible for expenditures for the patient under 104 CMR 30.01(9)(a) and (b);
3. the patient's legally authorized representative;
4. the patient's treatment team; and
5. other person who has deposited funds with the facility for the patient's benefit, but, in this instance, the accounting will be limited to an accounting for the funds actually deposited with the facility by said person.

(11) Making Purchases on Behalf of Patients. The facility shall have an obligation to assist patients in making purchases, and to inform patients of the availability of a shopping service for those patients who are unable to leave the facility. The shopping service shall be responsive to the individual needs and tastes of the patients.

(12) Social Security and Veterans Administration Income. When the facility director is designated by the Social Security Administration or the Veterans Administration as the representative payee of a patient, federal regulations govern the use of such funds. Accordingly, the facility director must comply with any policy directives or letters from the Social Security Administration or the Veterans Administration in regard to the use of these funds and income. To the extent allowed by Social Security or Veterans Administration requirements, the facility director may delegate the actual management of such funds to appropriate facility staff in accordance with the facility's written policies and procedures. In addition, 104 CMR 30.01 shall be followed to the extent that it is not inconsistent with Social Security or Veterans Administration requirements.

30.02: Client Funds in Community Programs

(1) Authority. 104 CMR 30.02 is promulgated under the authority of M.G.L. c. 19, §§ 1, 16, 18, and 19.

(2) Scope. 104 CMR 30.02 shall apply to community programs which are operated, contracted for, or licensed by the Department.

(3) No Department operated, contracted or licensed community program shall restrict the right of a client to acquire, retain and dispose of personally-owned funds, including the right to maintain an individual bank account, unless the client is a minor, or has a legally authorized representative with authority over such funds.

(4) A Department operated, contracted or licensed community program may hold funds of a client only if one of the following is applicable:

(a) The program director has been designated by the Social Security Administration or the Veterans Administration as the representative payee of a client. In such a situation federal regulations shall govern the use of such funds. Accordingly, the program director must comply with any policy directives or letters from the Social Security Administration or the Veterans Administration in regard to the use of these funds and income. To the extent allowed by Social Security or Veterans Administration requirements, the program director may delegate the actual management of such funds to appropriate program staff in accordance with the program's written policies and procedures. In addition, 104 CMR 30.02 shall be followed to the extent that it is not inconsistent with Social Security or Veterans Administration requirements.

(b) The program provides the client with housing, or supported residential services that are designed to assist the client in maintaining his or her residence, and the client or his or her legally authorized representative authorizes the program in writing to hold funds on behalf of the client. The client or legally authorized representative, if any, retains the unrestricted right to manage and spend the funds deposited with the program, if any, unless responsibility to manage and expend the deposited funds is delegated to the program director in writing (delegated funds).

(5) The following applies to programs that hold funds.

(a) If the program holds any funds pursuant to 104 CMR 30.02(4)(b) it must abide by the following restrictions:

1. A program may not hold or maintain more than $1,000 of a client's funds unless

the client is saving funds for a specific purpose that is described in the client's Individualized Action Plan in accordance with 104 CMR 29.11: *Individualized Action Plans* in which event a program may not maintain more than $2,000 of a client's funds.

2. Individual bank accounts shall not be established for individual clients by the program in the program name (jointly or otherwise). A program may assist a client in opening an account in his or her own name.

(b) If the program holds delegated funds pursuant to 104 CMR 30.01(4)(b) the following shall apply to such funds.

1. Delegated funds cannot be applied to goods or services which the program is obligated by law or funded by contract to provide to the client, which would already have been included in a charge for care, or which the patient is otherwise entitled to receive without charge.

2. The program or program staff cannot have a direct or indirect ownership or survivorship interest in the funds.

3. Expenditures of delegated funds shall be for a purpose which directly benefits the client and to which the client has agreed.

(c) In managing client funds held on behalf of a client,

1. The funds must be maintained in interest bearing accounts if commercially available and fiscally prudent.

2. If the funds are maintained in a group account, individual records must be maintained of each client's deposits and withdrawals and interest must be appropriately apportioned among the clients in the group.

3. Records. The program must be able to account for all funds received from a client or received on his or her behalf. A record shall be maintained for each client showing the amount of funds received, date received and source of the funds and for all funds disbursed, the amount, date disbursed, reason for disbursement, and to whom funds were disbursed.

4. Accounting. The following persons shall, upon their request, be provided a complete written account of all funds of a client, or, if requested, a written or oral statement of the current balance of funds of the client:

a. the client;

b. the client's legally authorized representative, if any;

c. if the program or an employee of the program is the representative payee of the client, the District Office of the Social Security Administration or the Veterans Administration concerning funds received from these agencies; and

d. the Department.

5. Internal Controls. The program must have written procedures concerning internal controls and accounting procedures for the management of client funds deposited with the program and such policies and procedures shall be fully implemented by the program.

6. The client's Individualized Action Plan pursuant to 104 CMR 29.11: *Individual Action Plans* shall address the client's needs for fiscal budgeting and management training and planning.

30.03: Reserved

30.04: Charges for Services

(1) Authority. 104 CMR 30.04 is promulgated under authority of M.G.L. c. 19, §§ 16 and 18, M.G.L. c. 123, § 32 and M.G.L. c. 6A, § 16.

(2) Scope. 104 CMR 30.04 applies to services for which the Department has an approved rate and that are provided by Department operated or contracted for facilities or programs. This includes the provision of room and board in a facility. Charges for room or board other than for that provided in a facility are governed by 104 CMR 30.06.

(3) Purpose. To maximize revenue for costs of services provided by Department operated or contracted for facilities and programs from federal and state benefits and private health insurance reimbursements as required by M.G.L. c. 6A, § 16, the Department must charge patients, clients or fee payers for the services it provides, contracts for, or otherwise funds. The purpose of 104 CMR 30.04 is to establish how the Department will charge for the

services for which it has approved rates and to allow for such charges to be adjusted on an individualized basis based on the ability to pay of the patient, client, or fee payer as determined in accordance with 104 CMR 30.04(7).

(4) Definitions. In addition to the terms defined in 104 CMR 25.02: Definitions, the following terms shall have the meanings set forth in this section throughout 104 CMR 30.04, unless the content clearly provides otherwise.

Approved Rate means the charge for a service which is established by the Department in accordance with applicable law.

Fee Payer means any of the following persons, each of whom may be liable for charges for services:

(a) the spouse of a patient or client, unless such spouse is legally separated, then only to the extent provided by a judicial order or separation agreement;

(b) the parent(s) of a minor child who is not an emancipated minor or a mature minor;

(c) the legally authorized representative or other person who controls assets of a patient or client, or the patient's or client's spouse or parent(s); provided, however, that the legally authorized representative or other person shall be responsible only to the extent he or she has control of a patient's or client's assets, or the assets of the patient's or client's spouse or parent(s), and only to the extent of such assets.

Income means monies received as recurrent payments, payments in kind or lump sum payments. Food stamps and other Supplemental Nutrition Assistance Program benefits, or like benefits provided through any successor program, are not income.

Liquid Assets means cash and all property capable of ready conversion into cash whether held jointly or solely. Liquid assets do not include life insurance or its cash value, nor assets subject to an irrevocable trust with the patient or client as named beneficiary, unless those assets are available to the patient or client or fee payer on demand.

Patient or Client means a person who receives services from a Department operated or contracted for facility or program.

Third Party Payer means an insurer, entitlement agency, or similar entity, which is obligated to pay for services provided to a patient or client.

(5) Charges for Services.

(a) The Department shall charge a patient, client or fee payer for the services provided to the patient or client by a facility or program operated or contracted for by the Department if the Department has an approved rate for the services.

(b) The charge shall be at the approved rate.

(c) A client is responsible for a charge unless the charge is covered by a third party payer.

(d) The Department shall adjust a charge based on a client's ability to pay in accordance with 104 CMR 30.04(7).

(6) Notification of Charges for Services. The Department shall give patients, clients and their fee payers, if known, notice that they will be charged for any services provided by a Department operated or contracted for facility or program for which the Department has an approved rate. Notice shall also be given to the patients' or clients' legally authorized representative if applicable.

(a) Such notice will be given:

1. at the time a patient or client, or his or her legally authorized representative, requests services;

2. upon admission to a facility operated or contracted for by the Department;

3. upon referral to any program operated or contracted for by the Department that provides a service for which the Department has an approved rate if not previously given;

4. at any time the approved rate for an applicable service changes;

5. annually thereafter as part of the patient's periodic review pursuant to 104 CMR 27.11: *Periodic Review*; or the review of the client's Individual Service Plan pursuant to 104 CMR 29.09: *Annual Review of the Individual Service Plan*; or if the client does not have an individual service plan, upon the annual review of the client's Individualized Action Plan pursuant to 104 CMR 29.13: *Review of the Individualized*

Action Plan;

6. upon request; and
7. at any other time deemed appropriate by the Department.

(b) The notice shall be on a form approved by the Department and shall provide the following information, at a minimum:

1. the approved rate for all of the applicable services for which the Department has an approved rate;

2. the right of the patient, client, his or her legally authorized representative or fee payer to request a reduction to a charge billed by the Department based on the patient's or client's financial circumstances and the fee payer's financial circumstances if the fee payer is either the spouse or parent(s) of the patient or client;
3. the name and telephone number of the Department office or employee available for further information; and
4. the right of the patient, client, their legally authorized representative, or fee payer to appeal a charge as established in 104 CMR 30.04(9).

(c) The Department shall offer to the patient, client, their legally authorized representative, or fee payer, the opportunity to have the notice explained to him or her by an appropriate representative.

(7) Billing a Patient, Client or Fee Payer.

(a) Determining Ability to Pay. Prior to billing charges that are the responsibility of a patient, client or fee payer, if the fee payer is the spouse or parent of a patient or client, the Department shall determine the ability to pay of the patient, client or fee payer. Based on the determination, the Department may reduce a charge or charges. The Department shall determine the ability to pay of a patient, client or fee payer and the amount by which charges may be reduced in accordance with the written policies of the Department. At a minimum, these policies must satisfy the following requirements:

1. In determining the ability to pay of a patient, client or fee payer, the Department will consider the patient's or client's income and liquid assets and those of a spouse or parent(s) if they are fee payers. If the spouse is legally separated from the patient or client, then the spouse's income and liquid assets will only be considered to the extent provided by a judicial order or separation agreement.
2. In calculating a patient's or client's income and liquid assets, or if applicable, the income and liquid assets of a spouse or parent(s), for the purpose of determining ability to pay, a certain amount of such income or liquid assets will be exempted to allow for the individual's support; the support of the individual's dependent(s) and, if applicable, spouse, and to permit the individual to maintain a residence in the community.
3. A reduction will not be permitted if the patient, client or fee payer requests that the Department not bill the charge to a third party payer or otherwise precludes the third party payer from paying the Department.
4. A reduction will not be permitted if the patient, client or fee payer does not provide the Department with the information needed to determine his or her ability to pay as specified by the Department's written policies regarding ability to pay.

(b) Review of Ability to Pay. The Department shall review the ability to pay of a patient or client, or if applicable, the patient's or client's spouse or parent(s), as follows:

1. when the patient or client first receives a service for which the Department has an approved rate;
2. annually;
3. on request of the patient or client, or his or her legally authorized representative;
4. on the request of the fee payer; and
5. whenever the Department has reason to believe that the ability to pay of the patient or client, or if applicable, the patient's or client's spouse or parent(s), has changed.

(c) Information. The patient or client, or if applicable, the patient's or client's spouse or parent(s), is responsible for providing or assisting the Department in obtaining the information needed to review his or her ability to pay. If the Department fails to receive such information, the Department may determine ability to pay based upon its best available information and proceed to bill and collect charges.

(d) Notice. Each patient and client and his or her legally authorized representative and applicable fee payer(s) shall receive notice of the determination of the ability to pay and whether a charge or charges will be adjusted, and of the right to appeal such determinations in accordance with 104 CMR 30.04(9).

(e) Billing a Client, Patient or Fee Payer. A patient, client or fee payer will be billed any charge not reduced to zero in accordance with 104 CMR 30.04(7). The bill shall include a statement of the charge(s), the reduction amount, if any, and the right to appeal the charge(s) as set forth in 104 CMR 30.04(9). Any charge or charges shall be due and payable within the time specified in the bill.

(8) Facility Director's Authority. If a patient who is billed for services has deposited funds with a facility director or designee of a Department facility such facility director or designee shall deduct the charges, or if appropriate, the reduced charges, from those funds; provided, however, that:

(a) The patient has capacity and the facility director or designee has requested in writing authority to deduct such charges and has received such authority from the patient; or

(b) The patient has a legally authorized representative and the facility director or designee has requested in writing authority to deduct such charges and has received such authority from the legally authorized representative; or

(c) The funds have been entrusted to the facility director or designee as the patient's representative payee; provided, however, that the patient will receive notice of the charge and any decision to reduce the charge and will have the appeal rights described in 104 CMR 30.04(9); and

(d) All notice provisions as specified above have been complied with; and

(e) No appeal of the charge or the Department's decision regarding a reduction of charge has been filed by the patient or representative, or if an appeal has been filed, it has been heard and decided; and

(f) The facility director or designee has first addressed the need for expenditure of such funds pursuant to the provisions of 104 CMR 30.01, and after he or she has first made all deductions and expenditures from such patient's funds pursuant to the policies promulgated under the provisions of 104 CMR 30.04(7).

For the purposes of 104 CMR 30.04(8)(a), (b), (c) and (d), the facility director or designee shall be deemed to have such authority if, within 30 days of requesting such authority in writing, the patient or legally authorized representative has not responded to such request so long as the facility director or designee has documented that the patient or other person has received such request and so long as the facility has taken reasonable steps to assist the patient or other person to understand the nature of the request.

(9) Appeal of Charges. Within 21 days after issuance of a bill, a patient, client, his or her legally authorized representative, or fee payer(s) may appeal the charge by notifying the Commissioner in writing. The notice must state what is being appealed and the basis for the appeal. The Commissioner may accept an appeal after 21 days for good cause.

(a) General Provisions.

1. To the extent possible, disagreements concerning a charge of a patient, client or fee payer should be resolved informally with the Area Director or designee prior to utilizing this appeal mechanism.

2. This appeal process has been established to comply with the State Comptroller's Office's requirements concerning debt collection, which are set out at 815 CMR 9.00: *Debt Collection and Intercept*.

(b) Grounds for Appeal. Grounds for appealing a charge shall be limited to the following:

1. Whether the client or patient, in fact, received the service for which he or she or the fee payer is billed;

2. Misidentification of the fee payer; or

3. Whether the amount billed was calculated in accordance with the Department's policy for reducing charges.

The rate that the Department charges for its services is not subject to appeal.

(c) The Commissioner or designee shall hear the appeal within 30 days of receipt of the appeal. The appellant shall be given an opportunity to present oral or written statements relevant to the charge, to question a representative of the Department concerning the charge, and to have a representative, if any, present. Such a proceeding shall not be an adjudicatory proceeding within the meaning of M.G.L. c. 30A. The standard of proof on all issues shall be a preponderance of the evidence and the burden of proof shall be on the appellant. The Commissioner shall make a decision within 30 days of hearing the case and shall notify in writing the appellant stating the reason for such decision. The decision of the Commissioner is final.

30.05: Canteen Operations

(1) Authority. 104 CMR 30.05 is promulgated pursuant to M.G.L. c. 19, §§ 1, 16 and 18, and pursuant to M.G.L. c. 123, §§ 2 and 23.

(2) Scope. 104 CMR 30.05 shall apply to facilities operated by the Department.

(3) General Provisions.

(a) A facility may conduct various activities and operations which are incidental to the mission of the facility and in which charges are made to patients, employees, or others for the goods or services sold. Activities and operations including vending machine operations, restaurant or snack bar operations, gift shops, concession stands, programs charging admission, and the like shall be known as Canteen Operations. The management of Canteen Operations shall be the responsibility of an employee or employees selected by the facility director. Such employee or employees may be assisted by patients and volunteers.

(b) The income from the Canteen Operations shall support the Canteen Operations. Income in excess of the cost of the Canteen Operations shall be called the Canteen Fund. The Canteen Fund shall be held by the financial manager of the facility. Canteen Funds shall be expended for the benefit of patients of the facility.

(c) The facility shall appoint a Canteen Committee. The facility director or his or her designee shall be the chairperson of this committee which will consist of members chosen as representatives of the following groups: facility staff, patients, and individuals concerned with the care and treatment of patients. At least two members of the Committee shall not be employees of the Department. The Canteen Committee will determine the expenditure of the Canteen Fund and provide advice on Canteen Operations.

(d) The facility must have written policies and procedures concerning internal controls and accounting procedures for the management of the Canteen Operations, the Canteen Fund, and, if applicable, the inventory of goods kept in the Canteen.

(e) The financial manager of the facility must file an annual report with the Deputy Commissioner of Administration and Finance and the Canteen Committee, regarding the Canteen Fund. The report shall include all deposits, withdrawals and the beginning and ending balances. Each annual report shall be in the form and manner prescribed by the Deputy Commissioner of Administration and Finance.

(f) Pursuant to M.G.L. c. 123, § 23, every patient shall have the right to keep and be allowed to spend a reasonable sum of his or her own money for canteen expenses and small purchases.

30.06: Charges for Room and Board in the Community

(1) Authority. 104 CMR 30.06 is promulgated under authority of M.G.L. c. 19, §§ 16 and 18, M.G.L. c. 123, § 32.

(2) Purpose and Scope.

(a) Charges for Room or Room and Board. The purpose of 104 CMR 30.06 is to establish the rules for charging adult clients in the community for room or room and board provided by Department operated or contracted for programs. The requirements set forth in 104 CMR 30.06 do not apply to room or room and board provided:

1. to facility patients;
2. as part of a shelter, respite, or crisis stabilization program as defined by the Department procurement activity codes;
3. as part of an individually procured residential placement; and
4. charges for services pursuant to 104 CMR 30.04.

(b) Other Charges or Fees.

1. Unless specifically authorized by the applicable Area Director in writing or by a contract to which the Department is a party, a Department operated or contracted for program only may charge clients, or ask clients for contributions for services and costs

a. pursuant to 104 CMR 30.04 or 30.06, or

b. related to specific client caused damages, when the cost of such damage is in excess of the usual expense of repair and replacement. Charges for specific client

caused damages that are in excess of the usual expense of repair and replacement are not subject to the dollar limits set forth in 104 CMR 30.06(6)(a).

2. A program may ask clients for contributions for non-service related activities that are not covered or paid for by the Department that the program offers (*e.g.*, extra recreational or entertainment activities); provided that participation is voluntary; contributions are only collected for those who wish to participate in the activities and the program has policies and procedures regarding the collection of such contributions and for providing assistance to those who cannot afford to participate in such activities.

(3) Definitions. As used in 104 CMR 30.06, the terms listed in 104 CMR 30.06(3) have the following definitions:

Board means the provision of daily meals. A program that provides board to its clients regularly offers its clients at least two full meals (i.e., breakfast, lunch or dinner) a day. This includes meals that are prepared by clients with food provided by the program. The meals must be provided on a regular fixed basis.

Client means an individual who receives room or room and board from a Department operated or contracted for program.

Client's Charge means the monthly amount a fee payer is responsible for paying for room or room and board as determined in accordance with 104 CMR 30.06(6).

Fee Payer means any of the following persons who may be liable for a client's charge: the client, a guardian, conservator, representative payee or other person who controls the funds of the client. A fee payer shall be responsible for the payment of a client's charges for room or room and board only if the fee payer controls the client's funds.

Room means sleeping accommodations. Room may be provided directly by a Department operated or contracted for program or a program may pay a third party (*e.g.*, rent to a local authority) for sleeping accommodations for a client. The sleeping accommodations must be provided on a regular fixed basis. Payments made by a Department operated or contracted for program that supplements rental payments made by clients (*i.e.*, clients are paying a portion of the rent) shall not be considered room for purposes of 104 CMR 30.06.

(4) Duty to Charge for Room or Room and Board; Notices.

(a) A Department operated or contracted for program that provides room or room and board to a client or otherwise pays for a client's room or room and board must charge the client monthly for the room or room and board in accordance with the provisions of 104 CMR 30.06 and must collect the charge from the client in accordance with 104 CMR 30.06(7).

(b) All notices required to be given to a fee payer other than the client under 104 CMR 30.06 shall also be provided to the client and to the client's legally authorized representative, if different.

(5) Notification of Client's Charge. A Department operated or contracted program that provides room or room and board to clients must provide each fee payer with a written notice that meets the requirements of 104 CMR 30.06(5).

(a) Contents. The notice must inform each fee payer of the following:

1. the fee payer's responsibility for paying the client's charge;
2. the amount of the client's charge and how that amount was calculated;
3. details as to when and how the fee payer is to pay the client's charge each month; and
4. the client's and, if different, the fee payer's responsibility for reporting the client's income and expenses to the program and for notifying the program of any changes in income or expenses that could result in a change in the client's charge by more than 10%. The notice shall indicate the individual, whom the client or fee payer is to contact at the program regarding changes in income and expenses, and the procedures for doing so; and
5. the appeal process as set forth in 104 CMR 30.06(9).

(b) Frequency. The notice must be provided: when a client first receives room or room and board from a program; when the client's charge is changed for any reason; upon request of the client, his or her legally authorized representative or fee payer and at any time the Department requests that notice be given. At a minimum, the notice must be provided at least 15 days prior to the client first being billed for room or room and board or, if applicable, 30 days before the implementation of an increase to a client's charge.

(6) Determination of Client's Charge.

(a) Determination of Client's Charge. The client's charge shall be the average statewide monthly cost of providing the room or room and board to clients in the community in state operated or contracted programs as determined by the Department in accordance

with 104 CMR 30.06(6)(b), subject to the following limits:

1. The client's charge may not exceed 75% of the client's average monthly income as determined in accordance with 104 CMR 30.06(6)(c); provided, however, that such charge shall be reduced by an amount necessary to assure that the client retains a minimum of $200 of his or her average monthly income.
2. If the client's average monthly income is $200 or less, the client's charge shall be zero.
3. If a Department operated or contracted for program receives state or federal housing assistance for the particular location where the client receives room or room and board, the determination of a client's charge for that location, must adhere to the applicable federal or state rules regarding the amount a tenant may pay for rent and utilities and, if appropriate, must reduce the client's charge as is necessary to comply with those rules.

(b) Determination of Monthly Cost for Providing Room or Room and Board to a Client. The Department, using generally accepted accounting principles and based on available financial information, shall determine on a fiscal year basis the statewide average monthly cost of providing room, and for providing room and board to clients in Department operated or contracted programs.

(c) Determination of a Client's Average Monthly Income. A client's average monthly income shall be determined by the sum of all gross income expected to be received by the client, or the client's fee payer on his or her behalf, over the next 12 months, minus necessary expenses as defined in 104 CMR 30.06(6)(d) and then dividing that total by 12. Income includes, but is not limited to:

1. compensation for services;
2. net income derived from a business;
3. military pay;
4. interest;
5. net rental income;
6. dividends;
7. annuities;
8. pensions;
9. unemployment compensation;
10. worker's compensation;
11. Veterans Administration benefits;
12. Social Security retirement, Supplemental Security Income and Social Security Disability Income benefits; and
13. trust benefits.

Such monies, payments in kind and lump sum payments will be counted as income in the month received and, thereafter, shall be defined as assets. Student financial assistance paid directly to the student or the educational institution and Supplemental Nutrition Assistance Program benefits (formerly known as Food Stamps), or like benefits provided through any successor program, shall not be counted as income.

(d) Necessary Expenses. Necessary expenses for purposes of 104 CMR 30.06(6)(c) is the sum of the following amounts which the client, or the client's fee payor on his or her behalf, is expected to pay over the next 12 months:

1. the cost of premiums to enroll and maintain the client in a health insurance program;
2. medical and dental expenses, including medication costs provided that such expenses are not covered by insurance or other third party payor and excluding co-payments;
3. child support or alimony payments owed by the client;
4. transportation expenses related to the implementation of the client's Individualized Service Plan that are not provided by a Department operated or contracted for program;
5. the cost of gas or electricity related to the room or room and board if the responsibility of client; and
6. other necessary expenses that are reflected in the client's Individualized Service Plan.

(e) Monthly Amount. Charges for room or room and board shall be calculated in monthly amounts. Charges for clients who receive room or room and board for less than

a month shall be adjusted *pro rata*.

(f) Multiple Programs. If a client receives room or room and board from more than one Department operated or contracted for program on any given day, the client or fee payer(s) shall only be charged for room or room and board by the program that provided the room that is considered the client's more permanent residence. If there is any issue regarding which one of the different programs is to bill, the issue shall be resolved by the applicable Area Director or designee.

(7) Program Responsibilities Regarding Charges. A Department operated or contracted for program that provides adult clients with room or room and board must comply with the following requirements:

(a) When a Client's Charge Must be Established. The program must establish a client's charge when the client first receives room or room and board from the program.

(b) Review of Client's Charge. A client's charge must be reviewed at least once every twelve months; or

1. Upon Request of a Client. If a program is notified by a client, or the client's legally authorized representative or fee payer of a change in client's circumstance that could result in a change in the client's charge by more than 10%, the program, within ten days of receipt of such notice, must recalculate the client's charge in accordance with 104 CMR 30.06(6) to determine if the amount actually has changed by more than 10% and it shall notify the client and client's legally authorized representative and fee payer(s), if any, of its findings. The notice must inform the client and the client's legally authorized representative and fee payer(s), if any, of the appeal process as set forth in 104 CMR 30.06(9).

2. Upon Change in the Monthly Cost of Providing the Room or Room and Board as Determined by the Department. A program must review client charges when there is a change to the average statewide monthly cost of providing room or room and board as calculated by the Department.

(c) Procedures. The program must have written procedures and appropriate internal controls regarding the collection of client charges for room or room and board.

(d) Collection. The program must collect monthly the client's charge as determined in accordance with 104 CMR 30.06(6). If a client/fee payer fails to pay for the client's room and board, the program shall address the issue, if appropriate, as part of the client's Individualized Action Plan in accordance with the procedures required by 104 CMR 29.00: *Application for DMH Services, Referral, Service Planning and Appeals*, or take other appropriate action. Failure to pay may be considered a violation of the program rules.

(e) Implementing a Change in Client's Charge.

1. An increase in a client's charge only may be implemented upon the Department operated or contracted for program giving the client and client's fee payer, if other than the client, 30 days written notice of the increase as provided in 104 CMR 30.06(7)(e)3.

2. A decrease in the client's charge shall be implemented no later than the first payment date after the decrease is determined.

3. The client and the client's fee payer, if other than the client, shall be given written notice of any change in the client's charge and the appeal process set forth in 104 CMR 30.06(9).

(f) Use. The amount collected for room or room and board from the client must be used to offset the Department's contract charges, if applicable, or distributed as determined by the Department in accordance with the Commonwealth's finance rules.

(g) Inability to Contribute. No client shall be denied room or board because of his or her inability to pay the client's charge.

(8) Responsibilities of the Client and Fee Payer for Reporting Income and Change in Circumstances.

(a) Payment of Charge. A fee payer is responsible for paying the client's charge monthly in a timely manner.

(b) Provide Information.

1. A client or fee payer, if other than the client, must provide the program with information on income and expenses upon the program's request. Additionally, the client or fee payer, if other than the client, must report a change in circumstances that could result in a change in the client's monthly charge for room or room and board, or a change in fee payer within ten days from the date he or she first learns of the change. Notwithstanding the provisions of 104 CMR 30.06(5)(b), failure to report a change in circumstances in a timely fashion may result in a retroactive change in a client's charge.

2. If a client or fee payer, if other than the client, fails to provide the information required by 104 CMR 30.06(8)(b), the program may determine the client's charge in accordance with 104 CMR 30.06(6), based upon its best available information and the

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program shall proceed to assess and collect from the fee payer the client's charge.

(9) Appeal of Charges.

(a) General Provisions.

1. 104 CMR 30.06(9) contains the standards and procedures for appeals by a client or fee payer of a client's charge.

2. To the extent possible, disagreements concerning a client's charge should be resolved informally with the Area Director, or designee, prior to utilizing this appeal mechanism.

3. Clients and fee payers, if any, shall be informed of their rights to appeal any assessed charge and any change in a client's charge pursuant to the provisions of 104 CMR 30.06(9).

4. During pendency of the appeal, the Department operated or contracted for program may continue to bill the fee payer for the client's charge.

(b) Subject Matter of an Appeal. The following issues may be appealed:

1. miscalculation of the charge; and
2. misidentification of the client or fee-payer.

(c) Initiation of an Appeal.

1. An appeal may be initiated by any of the following individuals:
   a. the client, or his or her legally authorized representative;
   b. the fee payer;
   c. the client or fee payer's legal advocate, if any;
   d. an individual designated by the client or fee payer as his or her representative.

2. An appeal is initiated by submitting a written statement to the Commissioner indicating what is being appealed and the basis for the appeal.

3. An appeal must be received by the Commissioner within 21 days of the client or fee payer being notified of the amount of the client's charge or, if applicable, of receipt of a decision regarding a request for adjustment under 104 CMR 30.06(6). The Commissioner may accept an appeal received after 21 days for good cause.

(d) The Appeals Process - Fair Hearing.

1. Within ten days of receipt of the written statement requesting an appeal, the Commissioner or designee shall appoint an impartial hearing officer, who shall schedule and conduct a fair hearing on a date which is agreeable to both parties. Said hearing shall be conducted in a manner consistent with M.G.L. c. 30A and 104 CMR 30.06(9)(d)1, and shall be governed by the informal fair hearing rules of the standard adjudicatory rules of practice and procedure, 801 CMR 1.02: *Informal/Fair Hearing Rules*.

2. The hearing officer may be an employee of the Department; provided, however, that no person shall be designated as a hearing officer in a particular appeal who is subject to the supervision of any facility, program or office within the service area in which the applicable Department operated or contracted for program is located.

3. The client or appealing party shall have the right to be represented at the hearing at his or her expense.

4. If the client is unrepresented at the hearing but needs assistance, or if for any other reason the Commissioner or designee determines it to be in the best interest of the client, the Commissioner or designee may designate an advocate to assist the client in the appeal.

5. The client or other appealing party and the program responsible for establishing the client's charge shall have the right to present any evidence relevant to the issues under appeal, and shall have the right to call, examine, and cross-examine witnesses.

6. The client or other appealing party and the program responsible for establishing the client's charge shall have the right to examine all records held by the Department or other parties upon which the applicable charge is based.

7. The fair hearing shall not be open to the public. The hearing officer may allow other persons to attend if he or she deems such attendance to be in the best interest of the client.

8. Within 20 days of the close of the hearing, the hearing officer shall prepare and submit to the Commissioner, or designee, a recommended decision which shall include a summary of the evidence presented, findings of fact, proposed conclusions of law, the recommended decision and the reasons for the decision.

9. The findings of fact in the recommended decision shall be binding on the Commissioner. The Commissioner or designee may modify the conclusions of law and decision where the conclusions or decision are: in excess of the Department's statutory authority or jurisdiction; based on an error of law; or arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law.

10. Within 15 days after receipt of the hearing officer's recommended decision, the Commissioner or designee shall issue a decision which shall be the final decision of the Department on all issues.

a. The Commissioner's or designee's decision shall include a summary of the evidence presented, findings of fact, a decision on each of the issues appealed and the reasons for such decision, and a notice of the individual's right to appeal the decision to the Superior Court pursuant to M.G.L. c. 30A.

b. The Commissioner's decision shall be mailed to the client, the appealing party and his or her legally authorized representative, if any, and to the program responsible for establishing the client's charge.

(e) Standard and Burden of Proof.

1. The standard of proof on all issues shall be a preponderance of the evidence.

2. The burden of proof on the issues specified in 104 CMR 30.06(9)(b)1. shall be on the program establishing the charge.

3. The burden of proof on all other issues specified in 104 CMR 30.06(9)(b) shall be on the appealing party.

(f) Judicial Review. A client or fee payer aggrieved by a final decision of the Department pursuant to 104 CMR 30.06(9) may, within 30 calendar days of receipt of the decision or a decision after a re-hearing, seek judicial review of the decision, in accordance with the standards and procedures contained in M.G.L. c. 30A, § 14.

(10) Transitional Provision. The Department anticipates issuing notice of program costs determined in accordance with 104 CMR 30.06(6)(b) on or before July 1, 2014, the issuance of which shall trigger programs' responsibility to initiate a review of client charges in accordance with 104 CMR 30.06(7). Program costs determined prior to issuance of such notice shall be utilized in determining client charges until then.

30.07: Disposition of Personal Property Abandoned at Facilities or Programs

(1) Authority. 104 CMR 30.07 is promulgated under authority of M.G.L. c. 19, §18 and M.G.L. c. 123, §§ 2 and 26.

(2) Purpose. To establish standard procedures for handling, controlling and disposing of personal property abandoned by patients at Department operated or contracted for facilities or by clients at residential sites that are operated by the Department or by a program contracted for by the Department.

(3) Scope. 104 CMR 30.07 applies to Department operated and contracted for facilities and Department operated and contracted for programs that operate residential sites as defined in 104 CMR 28.13: *Licensing: Physical Standards.*

(4) Definitions. As used in 104 CMR 30.07, the terms listed below have the following definitions.

(a) Abandoned Property means:

1. personal property that belongs to a patient and which is left behind by the patient after the patient is discharged from the facility; or
2. personal property that belongs to a client and which is left behind by the client at a program's residential site after the client leaves the residential site.

(b) Discharged means being formally discharged from a facility or being classified as absent without authorization (AWA) pursuant to 104 CMR 27.15: *Absence Without Authorization*, for six months.

(c) To Leave a Residential Site: means that the client has left a residential site with no intent to return.

(5) Patients and Clients are Responsible for Their Personal Property.

(a) Patients and clients are responsible for their personal property that they bring to or acquire while at a Department operated or contracted for facility or program. Facilities and programs are not responsible for damage to, loss of, or theft of the personal property of patients or clients.

(b) At the time of discharge from a facility, it is the patient's responsibility to remove or make arrangements for the removal of his or her personal property from the facility. Similarly, when a client leaves a residential site operated by a program, the client is responsible for removing or making arrangements for the removal of his or her personal property from the site.

(6) Notification of Policies Concerning Abandoned Property.

(a) Facilities. At the time of admission and again during the discharge planning process, or upon request, a facility must provide a patient and his or her legally authorized representative, if any, with written information on the facility's policies concerning the disposition of patients' personal property that is abandoned at the facility.

(b) Programs. When a client is initially provided with services at a residential site of a program and again ten or more days prior to a planned transition of the client from the residential site to another place of residence on a permanent basis, the program must provide the client and his or her legally authorized representative, if any, with written information on the program's policies concerning the disposition of personal property that is abandoned by clients at the program's residential sites. The information shall also be provided to clients or their legally authorized representatives upon their request.

(7) Storage of Abandoned Personal Property.

(a) A facility or program shall inventory and store abandoned personal property as soon as it is practical, but no later than ten days, after the patient is discharged from the facility or the client leaves the residential site of the program. A copy of the inventory shall be maintained in the record of the patient or client. The storage shall be appropriate for the nature and potential value of the abandoned property.

(b) Abandoned property shall be stored until such time as it is reclaimed by the patient or client or his or her legally authorized representative, if any, or it is disposed of in accordance with 104 CMR 30.07(9).

(8) Reasonable Efforts to Contact the Patient or Client. The facility and program shall make reasonable attempts to contact the patient or client or his or legally authorized representative, if any, to facilitate the return of the abandoned personal property. Such efforts shall include:

(a) Mailing a letter within ten days of the discharge of the patient from a facility or a client leaving the residential site operated by a program. The letter must be mailed to the last known address of the patient or client (other than the facility or program) and to his or her legally authorized representative, if any. A facility must also send a copy of the

letter to patient's next of kin. The letter must:

1. describe the abandoned property in sufficient detail so the patient or client will recognize it;

2. advise the patient or client to contact the facility or program as soon as possible to reclaim the property; and

3. inform the patient or client how long the abandoned property will be kept before it is disposed of by the facility or program.

(b) 30 days prior to disposing of any abandoned property pursuant to 104 CMR 30.07(9), the facility or program must again mail a letter to the patient or client to the last known address of the patient and client and to his or her legally authorized representative, if any. A facility or program must also send a copy of the letter to patient's next of kin. The letter must inform the patient or client that the facility or program intends to sell or otherwise dispose of the property in accordance with law if it is not reclaimed and removed from the facility or program within the next 30 days.

(c) When mailing the letters required by 104 CMR 30.07(8), the facility and program must, to the extent permitted by privacy and confidentiality statutes and regulations, check with other available resources to determine if a more recent address can be obtained. At a minimum, a Department operated program and facility shall ascertain if a more recent address for the patient or client exists in the Department's records. If a more recent address is obtained, a copy of the applicable letter shall also be sent to that new address.

(d) All efforts to contact the patient or client shall be documented in writing and kept in the record of the patient or client.

(9) Disposing of Abandoned Property. In disposing of abandoned property, a facility and program must abide by all applicable laws and regulations.

(a) Facilities.

1. A facility must retain abandoned property for at least one year after the patient's discharge prior to disposing of it.

2. Intangible personal property (*e.g.*, cash, checks, stocks, *etc*.) shall be disposed of by delivering it over to the State Treasurer in accordance with M.G.L. c. 123, § 26(b) and M.G.L. c. 200A.

3. Other personal property shall be disposed of as follows:

a. The facility director, or designee, shall determine if the property has sale value. If the property has sale value, the facility director or designee shall solicit offers for purchase from three reputable dealers in like property and shall sell the property to the highest bidder. The proceeds from the sale shall be given to the State Treasurer in accordance with M.G.L. c. 123, § 26(b) and M.G.L. c. 200A.

b. If the property is determined not to have sale value, or if no offer is received in response to solicitation for bids as described, the property may be disposed of in such a manner deemed appropriate by the facility director, or designee. This may include donating the property to charity or discarding the property.

c. A record of how a patient's abandoned property was disposed of shall be signed by the facility director or designee and filed with the former patient's facility records.

d. Staff of the facility shall not use, purchase or otherwise acquire the abandoned property.

(b) Programs.

1. A program must retain abandoned property for at least 60 days after the client leaves the program's residential site prior to disposing of it.

2. Intangible personal property shall be delivered to the State Treasurer in accordance with M.G.L. c. 200A.

3. Other personal property shall be disposed of as follows:

a. The program director or designee, shall determine if the property has sale value. If the property has sale value, the program director or designee shall solicit offers for purchase from three reputable dealers in like property and shall sell the property to the highest bidder. The proceeds from such sale shall be delivered to the State Treasurer in accordance with the procedures set forth in M.G.L. c. 200A.

b. If the property is determined not to have sale value, or if no offer is received in response to solicitation for bids as described, the property may be disposed of in such a manner deemed appropriate by the program director or designee. This

may include donating the property to charity or discarding the property.

c. A record of how a client's abandoned property was disposed of shall be signed by the program director or designee and filed with the client's program records.

d. Staff of the program shall not use, purchase or otherwise acquire the abandoned property.

30.08: Massachusetts Child Psychiatry Access Program Assessment

(1) Scope and Purpose. 104 CMR 30.08 governs the procedures for collecting an assessment to fund the Massachusetts Child Psychiatry Access Program (MCPAP) Assessment. The assessment is a surcharge on certain payments made to Massachusetts acute hospitals and ambulatory surgical centers.

(2) Definitions.

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

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

Department means the Massachusetts Department of Mental Health.

Department of Public Health means the Massachusetts Department of Public Health.

General Appropriations Act means the act of the General Court, or any subsequent amendment or supplemental act enacting the Commonwealth's fiscal year budget.

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

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

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

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

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

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

Payer means a surcharge payer that meets the criteria set forth in 104 CMR 30.08(4)(b).

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

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

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

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

1. Medicaid recipients under age 65; and
2. enrollees in the commonwealth care health insurance program; and provided further, that it may exclude amounts established under regulations promulgated by the Department for which the costs and efficiency of billing a surcharge payer or enforcing collection of the surcharge from a surcharge payer would not be cost effective.

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

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

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

(3) Determination of Assessment Liability and Payment.

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

1. payments subject to the assessment as defined in 104 CMR 30.08(3)(c); and
2. the assessment percentage as defined in 104 CMR 30.08(3)(d).

(b) Payers subject to assessment:

1. Payers are subject to the assessment if:
   a. the payer is a surcharge payer; and
   b. the payer's payments subject to surcharge were $1,000,000 or more during the previous state fiscal year or the most recent state fiscal year for which data is available.
2. The same entity that pays the hospital or ambulatory surgical center for services must pay the assessment.
3. A payer that pays for hospital or ambulatory surgical center services on behalf of a client plan must pay the assessment on those services. A payer that administers payments for health care services on behalf of a client plan in exchange for an administrative fee will be deemed to use the client plan's funds to pay for health care services whether the payer pays providers with funds from the client plan, with funds advanced by the payer subject to reimbursement by the client plan, or with funds deposited with the payer by the client plan.

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

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

1. The Department will, on an annual basis, determine the total amount expended on the MCPAP from line-item 5042-5000 of the Commonwealth's General Appropriations Act on behalf of commercial clients of Surcharge Payers in the previous fiscal year.

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

3. The assessment percentage is determined by dividing the total amount to be collected determined under 104 CMR 30.08(3)(d)1. by total projected aggregate payments determined under 104 CMR 30.08(3)(d)2.

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

(e) Each payer shall determine its assessment liability in accordance with guidance issued by the Department in Administrative Bulletins. The assessment liability is the product of the payer's payments subject to the assessment, as defined in 104 CMR 30.08(3)(c) and the assessment percentage as defined in 104 CMR 30.08(3)(d)3.

(f) Payers that pay a global fee or capitation for services that include hospital or ambulatory surgical center services, as well as other services not subject to the assessment, shall utilize the same reasonable method for allocating the portion of the payment intended to be used for services provided by hospitals or ambulatory surgical centers as the payer utilizes for such allocation pursuant to 105 CMR 223.00: *Pediatric Immunization Program Assessment*. A payer must include the portion of the global payment or capitation intended to be used for services provided by hospitals or ambulatory surgical centers, as determined by this allocation method, in its determination of payments subject to the assessment.

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

(h) Each payer shall pay its assessment liability in accordance with a schedule developed and released by the Department through Administrative Bulletin.

(4) Administrative Review.

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

(b) In conducting such review, the Department will review data submitted by hospitals, ambulatory surgical centers, and any other relevant data, including surcharge data. All information provided by, or required from, any payer, pursuant to 104 CMR 30.08 shall be subject to audit by the Department. For assessment liability payments based upon a global fee or capitation payment allocated according to an allocation method accepted by the Department pursuant to 104 CMR 30.08(3)(d)2., the Department's review will be limited to determining whether this method was followed accurately and whether the amounts reported were accurate.

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

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

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

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

1. the specific reason(s) for each of the payer's objections; and
2. all documentation that supports the payer's position.

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

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

(5) Other Provisions.

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

(b) Administrative Bulletins. The Department may issue administrative bulletins to clarify policies, update administrative requirements, and specify information and documentation necessary to implement 104 CMR 30.08.

(6) Severability. The provisions of 104 CMR 30.08 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 104 CMR 30.08 or the application of such provisions.

REGULATORY AUTHORITY

104 CMR 30.00: M.G.L. c. 19, §§ 1, 16, 18 and 19; c. 123, §§ 2, 4, 23, 25, 26(a), 32 and St. 2014, c. 165, Line Item 5042-5000.

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NON-TEXT PAGE