104 CMR 30.00: FISCAL ADMINISTRATION

Section

30.01: Patient Funds in Facilities

(1) 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 104 CMR 30.00, any reference to facility shall include a Department contracted inpatient unit.

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

Dependent Funds. 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(4);

(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.

Financial Manager. The individual appointed by the person in charge of a facility to manage patient funds held by the facility.

Funds. Cash, checks, negotiable instruments, or other income or liquid assets.

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

Liquid Assets. Cash and all property capable of ready conversion into cash, such as stocks and bonds, 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.

(3) 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(2).

(4) 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; and 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:

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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 behavioral health or medical condition 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 conducted 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 shall 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(8).

(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(4)(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 may result in damage to or loss of 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(4)(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(4)(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.

(5) 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(4), 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(4) 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.

(6) 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.

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(7) 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.

(8) 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 be responsible 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(8). 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 services provided to 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 service 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.

(9) 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 facility director or designee must file an annual report with the Department's Chief Financial Officer, 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 and the name of the individual(s) and facility listed on the account. Each annual report shall be in the form and manner prescribed by the Department's Chief Financial Officer.

(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.

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(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(8)(a) and (b);
3. the patient's legally authorized representative;
4. the patient's treatment team;
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: and
6. the Department's Chief Financial Officer or designee.

(10) 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.

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

(2) No Department operated or contracted 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.

(3) A Department operated, or contracted community program may hold funds of a client served by the program only if one of the following circumstances applies:

(a) The program, the vendor operating the program, or an employee of the program, has been designated by the Social Security Administration, the Veterans Administration, or another state or federal government entity, as the representative payee of the client.

(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, unless responsibility to manage and expend the deposited funds is delegated to the program in writing. The funds for which management responsibilities have been delegated to the program shall be referred to in 104 CMR 30.02(3) as delegated funds.

30.02: continued

(4) The following requirements apply to programs that hold client funds.

(a) If client funds are held pursuant to 104 CMR 30.02(3)(a), then:

1. the funds that may be held are limited to those that are received as representative payee by the program, the vendor operating the program, or an employee of the program;

2. the applicable federal or state regulations, policies and directives shall govern the holding and use of such funds; and

3. 104 CMR 30.02(4)(b)2 and 3 shall be followed to the extent they are not inconsistent with the applicable Social Security, Veterans Administration or other state or federal government entity's requirements.

(b) If the client funds are held pursuant to 104 CMR 30.02(3)(b), then:

1. Limit on the Amount That May Be Held. 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 Community Service Plan in accordance with 104 CMR 29.11: *Community Service Plan* in which event a program may not maintain more than $2,000 of a client's funds.

2. Expenditures. The following applies to how such funds can be expended:

a. 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 services or for residential services and supports in the community, or which the patient is otherwise entitled to receive without charge.

b. The Program and Program staff cannot benefit directly or indirectly in any expenditure.

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

3. Management of Funds. In managing funds held on behalf of a client,

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

b. 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.

c. 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.

d. 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:

i. the client;

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

iii. 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

iv. the Department.

4. 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.

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

6. The client's Community Service Plan pursuant to 104 CMR 29.11: *Community Service Plans* shall address, as appropriate, the client's needs and desires for fiscal budgeting and management training and planning.

30.03: Miscellaneous: (Reserved)

30.04: Charges for Services

(1) 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.

(2) 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(6).

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

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

Fee Payer. 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 separated, then only to the extent provided by a judicial order or a judicially approved separation agreement;
(b) the parent(s) of a minor child who is not an emancipated minor or a mature minor; or
(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. Any monies received by or on behalf of a client, including earned income, recurrent payments, payments in kind or lump sum payment. Income shall not include the following:
(a) Financial aid provided to full or part time students. This includes scholarships and stipends for housing or earnings from work-study programs that are included in a student's financial aid package;
(b) Payments made to and held by a client from the Supplemental Nutrition Assistance Program; or
(c) Income that is directly deposited into a Plan to Achieve Self-support (PASS) approved by the Social Security Administration.

Liquid Assets. Cash and all property capable of ready conversion into cash, such as stocks and bonds, regardless of whether such assets are held jointly or solely. Liquid assets do not include life insurance or its cash value, or 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. A person who receives services from a Department operated or contracted for facility or program.

Third-party Payer. An insurer, entitlement agency, or similar entity, which is obligated to pay for services provided to a patient or client.

(4) 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(6).

30.04: continued

(5) 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 Community Service Plan pursuant to 104 CMR 29.13: *Review of the Community Service 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(8).

(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.

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

(a) Determining Ability to Pay. In accordance with M.G.L. c. 123, § 32 and Department policies, the Department shall determine the ability of a patient, client or fee payer to pay the assessed charges. Based on the determination, the Department may reduce the amount to be collected for the assessed charges from the patient, client or fee payer. At a minimum, the Department 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 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 a judicially approved 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.

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(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(8).

(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(6). 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(8). Any charge or charges shall be due and payable within the time specified in the bill.

(7) 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(8); 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(6).

For the purposes of 104 CMR 30.04(7)(a) through (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.

(8) 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 as provided in 104 CMR 30.04(8)(b). The Commissioner may accept an appeal after 21 days for good cause.

30.04: continued

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

(2) 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 a person designated to hold such funds by the facility director. 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 person designated to hold the canteen funds 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 Residential Services and Supports in the Community

(1) Purpose and Scope.

(a) Charges for Residential Services and Supports in the Community. 104 CMR 30.06 sets forth the rules governing assessment and collection of charges for residential services and supports provided in the community by a Department operated or contracted for the program. The requirements set forth in 104 CMR 30.06 do not apply to residential services and supports provided:

1. by a DMH operated or contracted facility;
2. as part of a shelter, respite, or crisis stabilization program as defined by the Department procurement activity codes;
3. as part of a procured residential placement for a specific individual;
4. as part of another service for which a fee payer is charged pursuant to 104 CMR 30.04 if the charge includes community residential services and supports; or
5. to clients who are minors.

(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.
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.

(2) 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 30.06(2), unless the content clearly provides otherwise.

Client. An individual who receives residential services or supports from a Department operated or contracted for program.

Earned Income. Income derived from active participation in a trade or business, including wages, salary, tips, commissions, bonuses, and net earnings from self-employment.

Fee Payer. A legally authorized representative or other person who controls funds of the client; provided however, that the legally authorized representative or other person is liable only with respect to the client's funds under his or her control.

Income. Any monies received by or on behalf of a client, including earned income, recurrent payments, payments in kind or lump sum payment. Income shall not include the following:

(a) Financial aid provided to full or part time students. This includes scholarships and stipends for housing or earnings from work-study programs that are included in a student's financial aid package;

(b) Payments made to and held by a client from the Supplemental Nutrition Assistance Program; or

(c) Income that is directly deposited into a Plan to Achieve Self-support (PASS) approved by the Social Security Administration.

Liquid Asset. Cash and all property capable of ready conversion into cash, such as stocks and bonds, regardless of whether such assets are held jointly or solely. Liquid assets do not include life insurance or its cash value, or 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.

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Monthly Residential Services and Supports Cost. The median of the statewide monthly cost per client for providing residential services and supports in Department operated and contracted programs as determined by the Department. Costs attributable to rehabilitative services are not included determining the statewide monthly cost of providing residential services and supports.

Recurrent Payment. Income received at regular intervals, though not necessarily in constant amounts, and includes, but is not limited to:

(a) compensation for services and other earned income;
(b) net income derived from a business;
(c) interest;
(d) net rental income;
(e) dividends;
(f) annuities;
(g) pensions;
(h) unemployment compensation;
(i) worker's compensation;
(j) royalties;
(k) Veterans Administration benefits;
(l) Social Security retirement, Supplemental Security Income and Social Security Disability Income benefits;
(m) Old Age and Survivor Disability Insurance benefits; and
(n) trust benefits

Residential Services and Supports. Services delivered in staffed group living environments that provide clients with a place to reside on a regular fixed basis and assistance aimed specifically at enabling the clients to maintain their residence. It does not include rehabilitative services that also may be provided to clients receiving residential services and supports.

Residential Services and Supports Charge. The portion of the monthly residential services and supports cost to be charged to a client or fee payer(s).

(3) Duty to Charge for Residential Services and Supports.
A Department operated or contracted for program that provides residential services and supports must charge the clients receiving such services and supports and the respective fee payers monthly and collect the charge in accordance with 104 CMR 30.06, unless the charge is reduced in its entirety pursuant to 104 CMR 30.06(6).

(4) Notice.

(a) A Department operated or contracted program that provides residential services and supports to clients must inform each client and his or her legally authorized representative, if any, by written notice that he or she will be charged for the residential services and supports provided to the client. The notice must also be given to a client's fee payer(s), if applicable. The notice must be provided:

1. as soon as practical after the client starts receiving residential services and supports from the program;
2. at least 30 days prior to the program implementing a change in amount of the client's charge for residential services and supports;
3. upon request of the client, his or her legally authorized representative, or fee payer; and
4. at such other times deemed appropriate by the Department.

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

1. the client and fee payer's responsibility for paying monthly the charge for residential services and supports;
2. the client's or fee payer's charge for residential services and supports and how it was calculated;
3. in determining the monthly charge for residential services and supports, there is an incentive for clients to work in that earned income which is factored only at 50% and unearned income factored at 75%;

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4. the client or fee payer's responsibility for reporting changes of ten percent or more to the client's income and expenses and how such changes are to be reported;
5. details as to when and how the charge is to be paid each month; and
6. the right to the appeal process as set forth in 104 CMR 30.06(10).

(5) Determination of a Client's Charge and Collection of Charge.

(a) Determination of a Client's Charge. A client charge for residential services and supports shall be calculated as follows:

1. Client Receiving Recurrent Payments. For a client receiving recurrent payments, the monthly residential service and supports charge shall be an amount equal to 75% of the client's recurrent payment (not including earned income), if any, plus 50% of the client's earned income, if any, received in the month for which the charge for residential services and supports accrued; provided, however, that the charge is subject to the following reductions:

a. Reduction by the amount the charge exceeds, if any, the monthly residential and support services cost.

b. Reduction by the amount necessary to ensure that the client retains a minimum of $200 of his or her monthly's recurrent payments (including earned income).

c. Reduction by the amount of adjustment permitted under 104 CMR 30.06(6).

d. Reduction by the amount the charge exceeds, if any, the amount permitted to be charged by the terms of a law, a regulation, or a housing subsidy held by the client or the program.

2. Client Not Receiving Recurrent Payments. For a client who does not receive recurrent payments, but has liquid assets, the monthly residential services and supports charge shall be an amount equal to 75% of the appropriate Supplemental Security Income benefit level for the "SSI Payment Standard" category that is in effect in the month the charge for residential services and supports accrued; provided however, such charge is subject to the following reductions:

a. Reduction by the amount the charge exceeds, if any, the monthly residential and support services cost.

b. Reduction by the amount necessary to assure that the client retains a minimum of $1,000 of his or her liquid assets.

c. Reduction by the amount of adjustment permitted under 104 CMR 30.06(6).

d. Reduction by the amount the charge exceeds, if any, the amount permitted to be charged by the terms of a law, a regulation, or a housing subsidy held by the client or the program.

(b) Determination of a Client's Charge. A program shall determine a client's monthly residential services and supports charge as soon as practical after the client starts receiving residential services and supports from the program and at least annually thereafter. The charge shall also be reviewed upon:

1. notification by the client or fee payer of a change in the client's income or expenses in an amount equal to or greater than ten percent; and
2. notification by the Department of a change in the monthly residential services and supports cost.

(c) Change in a Client's Charge.

1. Each client and his or her legally authorized representative and fee payer, if any, shall receive a notice of a change to his or her charge at least 60 days prior to the implementation of such change and notice as to whether, pursuant to a request, a charge will be adjusted pursuant to 104 CMR 30.06(6). Such notices shall include information about the right to appeal such determinations in accordance with 104 CMR 30.06(10) and, when a phase-in of an increase is required pursuant to 104 CMR 30.06(5)(c)2., information as to how that will be done.

2. If as a result of the change the client (or fee payer) will pay an additional amount of greater than $100, then the increase resulting from the change shall be phased in proportionally over a 12-month period, so that at the end of the 12-month period, the client (or fee payer) is paying the new charge in full.

(d) A Department operated or contracted program that provides residential services and supports is responsible for billing and collecting the monthly residential services and support charge from clients and fee payers, or a combination thereof, in a timely manner; except as provided in 104 CMR 30.06(5)(c).

30.06: continued

(6) Adjustment to Charges. For a client who has necessary expenses but does not have sufficient funds to pay for these expenses in a particular month, the charge for residential services and supports shall be reduced that month by an amount that will enable the client to pay such expenses. Expenses deemed necessary are the following:

(a) The cost of premiums to enroll and maintain the client in a health insurance program;

(b) Medical and dental expenses, including medication costs, provided that such expenses are not covered by insurance or other third-party payor;

(c) The Costs for co-payments for medical and dental costs;

(d) Child support or alimony payments owed by the client;

(e) Loan payments, but only if the loan was incurred by the individuals to pay for expenses enumerated in 104 CMR 30.06(6); or were incurred prior to receiving the residential services and supports at the applicable Department operated or contracted for the program;

(f) Transportation expenses related to the implementation of the client's Community Service Plan that are not provided by a Department operated or contracted for the program; and

(g) Other expenses necessary to implement activities in a client's Community Service Plan.

(7) Responsibility of the Client and Fee Payers.

(a) Client and fee payers shall provide information on income, assets and expenses of the client to the Department or program upon request and shall report changes to income, assets and expenses when the amount of such changes equals or exceeds ten percent of what has been previously reported. Clients and fee payers must report each such change in circumstance within ten days from the date they first learn of the change.

(b) In the case where information is not reported as required in 104 CMR 30.06(7), the Department operated or contracted for the program may determine the charge and adjustment upon the best available information, and proceed to assess and collect charges for residential services and supports. The 60-day limitation for income set forth in 104 CMR 30.06(2) shall not apply to unreported changes in funds available to pay the charges.

(c) Clients and fee payers shall pay charges in a timely manner each month.

(8) Multiple Programs. If a client receives residential services and supports from more than one Department operated or contracted for the program on any given day, the client and if applicable, fee payer(s), shall only be charged for residential services and supports at the program 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.

(9) Program Director's Authority. If a client is charged for residential services and supports by a program with which he or she has deposited funds with the program director or designee in accordance with 104 CMR 30.02, the program may deduct the charges or, if appropriate, the adjusted charges from those funds; provided however, that:

(a) the program director, or designee, has requested in writing to the authority to deduct such charges and has received such authority from the client or the client's legally authorized representative; or

(b) the funds have been entrusted to the program director or designee as the client's representative payee; and

(c) all notice provisions as specified in 104 CMR 30.06 have been complied with; and

(d) no appeal of the charge has been filed by the client or representative, or if an appeal has been filed it has been heard and the charge has been finally determined.

For the purpose of 104 CMR 30.06(9)(a), the program director or designee shall be deemed to have such authority if within 14 days of requesting such authority in writing the client or legally authorized representative has not responded to such request.

(10) Appeal of Charges.

(a) Grounds for Challenging a Charge. Grounds for challenging a charge (including by appeal) shall be as follows:

1. Miscalculation of the charge;
2. Misidentification of the fee payer; or
3. Failure to adjust the charge to account for necessary expenses in accordance with 104 CMR 30.06(6).

30.06: continued

(b) Informal Resolution.

1. Within seven days of receipt of notice of a change in a client's charge, the client or fee payer, or client representative shall notify the program that the client has grounds for challenging the charge as provided in 104 CMR 30.06(10)(a).

To the extent possible, disputes concerning a client's charge should be resolved informally with the program, within five days of notice from the client of a dispute.

2. If the dispute cannot be resolved within the program, the program and client shall present the dispute to the Area Director or designee for review and resolution.

3. If within ten days the Area Director or designee is unable to resolve the dispute, the client, fee payer or client representative may appeal the charge to the Commissioner pursuant to this section.

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

(c) Appeal to the Commissioner. Following informal resolution effort, but no longer than 30 days after being notified of the amount of the monthly charge, the client or fee payer, or client representative may appeal the charge by notifying the Commissioner in writing. The notice must state the name of the program assessing the charge and the basis for the appeal as provided in 104 CMR 30.06(10)(c). The Commissioner may accept an appeal after 30 days for good cause.

(d) During the pendency of the appeal, the Department or provider shall continue to bill the client and fee payer the monthly charge for residential services and supports.

(e) The Commissioner or designee shall hear the appeal within 30 days of receipt of the appeal.

1. The client or fee payer or client representative shall be given an opportunity to present oral or written statements relevant to the charge, to question a representative of the Department or program concerning the charge, and to have a representative, if any, present.

2. The standard of proof on all issues shall be a preponderance of the evidence and the burden of proof shall be on the appellant.

3. Such a proceeding shall not be an adjudicatory proceeding within the meaning of M.G.L. c. 30A.

4. 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.

(11) Transitional Provision.

(a) The Department anticipates issuing notice of the residential services and supports cost in accordance with 104 CMR 30.06(2) concurrent with the effective date of this regulation, the issuance of which shall trigger programs' responsibility to initiate the new charge for residential services and supports in accordance with 104 CMR 30.06. Until such notice is given the charge for room and board under the former regulation 104 CMR 30.06 shall continue.

(b) If as a result of the promulgation of this regulation a client's monthly charge for residential services and support is greater than what the client (or fee payer) was being charged for room and board under the former regulation 104 CMR 30.06 by more than $100, then the increase resulting from the change shall be phased in proportionally over a 12-month period, so that at the end of the 12-month period, the client and fee payer is paying the new charge for residential services and support in full.

30.07: Disposition of Personal Property Abandoned at Facilities or Programs

(1) Purpose. To establish standard procedures for handling, controlling and disposing of personal property abandoned by patients at the 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.

(2) Scope. 104 CMR 30.07 applies to the 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*.

30.07: continued

(3) Definitions. As used in 104 CMR 30.07, the terms listed in 104 CMR 30.07(3) have the following definitions.

(a) Abandoned Property.

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.

(4) 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.

(5) 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. The information shall also be provided to clients or their legally authorized representatives upon their request.

(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.

(6) 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(8).

(7) 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. 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.

30.07: continued

(b) 30 days prior to disposing of any abandoned property pursuant to 104 CMR 30.07(8), 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 only 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(7), 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.

(8) 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. 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. 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. The Massachusetts Department of Mental Health.

Department of Public Health. The Massachusetts Department of Public Health.

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

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

Indirect Payment. 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. A managed care organization as defined in M.G.L. c. 118E, § 64.

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

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

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

Payments Subject to Surcharge. 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:

30.08: continued

1. Medicaid recipients younger than 65 years old; 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. The surcharge on payments made to hospitals and ambulatory surgical centers established by M.G.L. c. 118E, § 68.

Surcharge Payer. 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. 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 the Commonwealth's General Appropriations Act, Line Item 5042-5000 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.

30.08: continued

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.

30.08: continued

(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; M.G.L. c. 123, §§ 2, 4, 23, 25, 26(a) and 32; M.G.L. c. 6A, § 16, and St. 2014, c. 165, Line Item 5042-5000.