114.6 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY
MEDICAL SECURITY BUREAU

114.6 CMR14:00: HEALTH SAFETY NET PAYMENTS AND FUNDING

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14.01 General Provisions

(1) Scope, Purpose and Effective Date. 114.6 CMR 14.00 governs payments to and from the Health Safety Net Trust Fund effective October 1, 2008, including payments to acute hospitals and community health centers and payments from acute hospitals and surcharge payers. 114.6 CMR 13.00 specifies the criteria for determining the services for which hospitals and community health centers may be paid from the Health Safety Net Trust Fund.

(2) Authority: 114.6 CMR 14.00 is adopted pursuant to M.G.L. c. 118G.

14.02 Definitions

Meaning of Terms: As used in 114.6 CMR 14.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 114.6 CMR 14.00 are capitalized.

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

Allowable Reimbursement. Payments to Acute Hospitals and Community Health Centers for health services provided to uninsured residents of the Commonwealth as further defined in 114.6 CMR 13.00.

Ambulatory Surgical Center. Any distinct entity 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 USC § 1395k(a)(2)(F)(i). These services include only facility services and do not include physician fees.

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

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

Community Health Center. A health center operating in conformance with the requirements of Section 330 of United States Public Law 95-926, including all community health centers which file cost reports as requested by the Division of Health Care Finance and Policy (Division). Such health center must:

(a) be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51;
(b) meet the qualifications for certification (or provisional certification) by the Office of Medicaid and enter into a provider agreement pursuant to 130 CMR 405.000; and
(c) operate in conformance with the requirements of 42 U.S.C. § 254(c).

Disproportionate Share Hospital (DSH). A Hospital where a minimum of 63% of the Gross Patient Service Revenue is attributable to Title XVIII and Title XIX of the Social Security Act, other government payers, including Commonwealth Care, and uncompensated care, as further defined in 114.6 CMR 14.03(2)(b).

Eligible Services. Reimbursable Health Services for which Providers may submit a claim for Health Safety Net Payments in accordance with 114.6 CMR 13.00. Eligible Services include Eligible Services to Low Income Patients that meet the criteria in 114.6 CMR 13.03; Medical Hardship services that meet the criteria in 114.6 CMR 13.04; and Bad Debt that meets the criteria in 114.6 CMR 13.05.

Emergency Bad Debt. The amount of uncollectible debt for emergency services that meets the criteria set forth in 114.6 CMR 13.05.

Family Income. Gross earned and unearned income as defined in 130 CMR 506.003.

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

Financial Requirements. A hospital's requirement for revenue which shall include, but not be limited to, reasonable operating, capital and working capital costs, and the reasonable costs associated with changes in medical practice and technology.

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

Fund. The Health Safety Net Trust Fund, established by M.G.L. c. 118G §36.

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

Gross Patient Service Revenue (GPSR). The total dollar amount of a hospital's charges for services rendered in a Fiscal Year.

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

Health Insurance Plan. The Medicare program, the MassHealth program, Commonwealth Care, or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, as defined in M.G.L. c. 175, c. 176A, c. 176B, c. 176G, or c. 176I.

Health Safety Net Office. The Office within the Division of Health Care Finance and Policy established under M.G.L. c. 118G, § 35.

Health Services. Medically necessary inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Health services shall not include: (1) nonmedical services, such as social, educational and vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and consultations; (5) court testimony; (6) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-surgery hormone therapy; and (7) the provision of whole blood, but the administrative and processing costs association with the provision of blood and its derivatives shall be payable.

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 by the Department of Public Health. This does not include services provided in transitional care units; services provided in skilled nursing facilities; and home health services, or separately licensed services, including residential treatment programs and ambulance services.

Indirect Payment. A payment made by an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I to a group of providers, including one or more Massachusetts acute care Hospitals or Ambulatory Surgical Centers, that then forward the payment to member Hospitals or Ambulatory Surgical Centers; or a payment made to an individual to reimburse him or her for a payment made to a Hospital or Ambulatory Surgical Center.

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

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

Low Income Patient. A patient who meets the criteria in 114.6 CMR 13.03.

MassHealth. 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.

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

Patient. An individual who receives or has received Eligible Services at a Hospital or Community Health Center.

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

Pediatric Hospital. An acute Hospital which limits services primarily to children and which qualifies as exempt from the Medicare Prospective Payment System (PPS).

Private Sector Charges. Gross Patient Service Revenue attributable to all patients less Gross Patient Service Revenue attributable to Titles XVIII, XIX, and XXI, other publicly aided patients, For each Fiscal Year, a Hospital's Private Sector Charges are determined using data reported in the RSC-403 for that Fiscal Year.

Provider. A Hospital or Community Health Center that provides Eligible Services.

Publicly Aided Patient. A person who receives Hospital or Community Health Center care and services for which a Governmental Unit is liable in whole or in part under a statutory obligation.

Registered Payer List. A list of Institutional Payers as defined in 114.6 CMR 14.06(3)(b).

Shortfall Amount. In a Fiscal Year, the positive difference between the sum of Allowable Health Safety Net care costs for all Hospitals and the revenue available for distribution to Hospitals.

Sole Community Hospital. Any acute Hospital classified as a Sole Community Hospital by the U.S. Centers for Medicare and Medicaid Services' Medicare regulations, or any Hospital that demonstrates to the Health Safety Net Office's satisfaction that it is located more than 25 miles from other acute Hospitals in the Commonwealth and that it provides services for at least 60% of its primary service area.

Surcharge Payer. An individual or entity that (a) makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; and (b) meets the criteria set forth in 114.6 CMR 14.05(1)(a).

Surcharge Percentage. The percentage assessed on certain payments to Hospitals and Ambulatory Surgical Centers determined pursuant to 114.6 CMR 14.05(2).

Term Bills. A claim for outpatient services, including, but not limited to, therapy services, that includes charges for multiple dates of service.

Third Party Administrator. An entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee. A Third Party Administrator

may provide client services for a self-insured plan or an insurance carrier's plan. Third Party Administrators will be deemed to use a client plan's funds to pay for health care services whether the Third Party Administrator pays providers with funds from a client plan, with funds advanced by the Third Party Administrator subject to reimbursement by the client plan, or with funds deposited with the Third Party Administrator by a client plan.

Uncompensated Care Pool. The fund established under M.G.L. c. 118G, § 18 to pay hospitals and community health centers for health services provided to low income uninsured and underinsured individuals.

Urgent Care. Medically necessary services provided in a Hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a patient's health in jeopardy; impairment to bodily function, or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life-threatening and do not pose a high risk of serious damage to an individual's health. Urgent care services do not include elective or primary care.

14.03 Sources and Uses of Funds

(1) Available Revenue. Revenue available to fund Provider payments from the Health Safety Net Trust Fund consists of:

(a) revenue produced by Hospital assessments and the Surcharge on Hospital and Ambulatory Surgical Center payments;
(b) funds authorized to be transferred from the Commonwealth Care Trust Fund;
(c) amounts transferred from the Uncompensated Care Trust Fund;
(d) any interest on monies in the Health Safety Net Trust Fund; and
(e) any additional funding made available through appropriation by the general court.

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

(a) Hospital Payments established under 114.6 CMR 14.06 may be adjusted to reflect additional funding made available during the Fiscal Year or to reflect the Shortfall Allocation in accordance with 114.6 CMR 14.03 (2). The Health Safety Net Office may reserve up to 10% of available funding to ensure that funding will be available for the entire Fiscal Year.
(b) Shortfall Allocation. The Health Safety Net Office shall, using the best data available, estimate the projected total Reimbursable Services provided by Hospitals, Community Health Centers and total Bad Debt for FY 2009. If the Office determines that, after adjusting for projected Community Health Center payments, Health Safety Net payments to Hospitals will exceed available funding, the Office shall allocate the funding in a manner that reflects each Hospital's proportional financial requirements for Health Safety Net payments through a graduated payment system. The Health Safety Net Office will allocate the shortfall to Disproportionate Share Hospitals and other Hospitals as follows:

1. Disproportionate Share Hospital. The Office will determine Disproportionate Share Hospital status using data from the FY 2007 DHCFP-403 cost report as follows.

a. Determine all Hospitals with more than 63% of GPSR attributable to Medicare, Medicaid or uncompensated care.

b. Determine each Hospital's FY 2007 uncompensated care payments by multiplying the Hospital's free care charges from the FY2007 Uncompensated Care Pool (UCP) claims data by the cost to charge ratio calculated using the FY2007 DHCFP-403 cost report.

c. Rank the Hospitals from highest to lowest based on the ratio of FY 2007 uncompensated care costs to total statewide uncompensated care costs.

d. The 16 Hospitals with the highest ratios of uncompensated care costs to total statewide uncompensated care costs are Disproportionate Share Hospitals.

2. Shortfall Allocation. The Health Safety Net Office will allocate the shortfall as follows:

a. Determine the ratio of each Hospital's total patient care costs to the sum of all Hospitals' total patient care costs;

b. Multiply this ratio by the total Shortfall Amount

c. If calculated amount is greater than a Hospital's allowable Health Safety Net payments, then the shortfall allocation will be limited to the Hospital's allowable Health Safety Net payments.

d. The Health Safety Net's gross liability to each Hospital is limited by the Hospital's allowable Health Safety Net payments less the Shortfall Allocation Amount.

e. Each Disproportionate Share Hospital will be paid the greater of:

i. 85% of its Allowable Health Safety Net payments: or

ii. the revised payment calculated according to the shortfall methodology in 114.6 CMR 14.03(2)(b)1. through 4.

14.04 Total Hospital Assessment Liability to the Health Safety Net Trust Fund

A Hospital's gross liability to the Health Safety Net Trust Fund is the product of (a) the ratio of its Private Sector Charges to all Hospitals' Private Sector Charges and (b) $180 million, the total Hospital liability to the Health Safety Net Trust Fund pursuant to M.G.L. c. 118G, §37.

14.05 Surcharge on Hospital Payments

(1) General. There is a surcharge on certain payments to Hospitals and Ambulatory Surgical Centers. The surcharge amount equals the product of (a) payments subject to surcharge as defined in 114.6 CMR 14.05(1)(b) and (b) the Surcharge Percentage as defined in 114.6 CMR 14.05(2).

(a) Surcharge Payer.

1. A Surcharge Payer is an individual or entity that makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; provided, however, that the term "surcharge payer" shall not include (1) Title XVIII and Title XIX programs and their beneficiaries or recipients; (2) other governmental programs of public assistance and their beneficiaries or recipients; and (3) the workers compensation program established pursuant to M.G.L. c.152.
2. The same entity that pays that Hospital or Ambulatory Surgical Center for services must pay the surcharge. If an entity such as a Third Party Administrator acts on behalf of a client plan and uses the client plan's funds to pay for the services, or advances funds to pay for the services for which it is reimbursed by the client plan, it must also act on behalf of the client plan and use the client plan's funds to pay the surcharge or advance funds to pay the surcharge for which it will be reimbursed by the client plan.

(b) Payments subject to surcharge. Payments subject to surcharge include:
1. direct and Indirect Payments made by Surcharge Payers on or after January 1, 1998, regardless of the date services were provided, to: (1) Massachusetts acute hospitals for the purchase of acute Hospital Services; and (2) Massachusetts Ambulatory Surgical Centers for the purchase of Ambulatory Surgical Center Services.
2. payments made by national health insurance plans operated by foreign governments; and payments made by an embassy on behalf of a foreign national not employed by the embassy.

(c) Payments not subject to surcharge. Payments not subject to surcharge include:
1. payments, settlements and judgments arising out of third party liability claims for bodily injury that are paid under the terms of property or casualty insurance policies;
2. payments made on behalf of Medicaid recipients, Medicare beneficiaries, persons enrolled in Commonwealth Care, or persons enrolled in policies issued pursuant to M.G.L. c. 176K or similar policies issued on a group basis;
3. payments made by a Hospital to a second Hospital for services that the first Hospital billed to a Surcharge Payer;
4. payments made by a group of providers, including one or more Massachusetts acute care Hospitals or Ambulatory Surgical Centers, to member Hospitals or Ambulatory Surgical Centers for services that the group billed to an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I;
5. payments made on behalf of an individual covered under the Federal Employees Health Benefits Act at 5 U.S.C. 8901 et seq.;
6. payments made on behalf of an individual covered under the workers compensation program under M.G.L. c. 152; and
7. payments made on behalf of foreign embassy personnel who hold a Tax Exemption Card issued by the United States Department of State.

(d) The surcharge shall be distinct from any other amount paid by a Surcharge Payer for the services provided by a Hospital or Ambulatory Surgical Center. Surcharge amounts paid shall be deposited in the Health Safety Net Trust Fund.

(2) Calculation of the Surcharge Percentage. The Health Safety Net Office will use the following methodology to calculate the percentage of the surcharge to be assessed on certain payments to Hospitals and Ambulatory Surgical Centers, established in M.G.L. c.118G, § 38**.** The Health Safety Net Office will establish the Surcharge Percentage before September 1 of each year, as follows:

(a) The Health Safety Net Office will determine the total amount to be collected by adjusting $160,000,000 for any over or under collections from Institutional Payers and individuals in previous years, including audit adjustments, as well as any over or under collections projected for October or November of the coming year.

(b) The Health Safety Net Office will project annual aggregate payments subject to the surcharge based on historical data, with any adjustments the Health Safety Net Office deems necessary.

(c) The Health Safety Net Office will divide the amount determined in 114.6 CMR 14.05(2)(a) by the amount determined in 114.6 CMR 14.05(2)(b).

(3) Payer Registration.

(a) Except for non-United States national insurers that have made less than ten payments per year in the prior three years to Massachusetts Hospitals and/or Ambulatory Surgical Centers, all Institutional Payers must register with the Health Safety Net Office by completing and submitting the Surcharge Payer Registration form. Institutional Payers must register only once. These payers shall submit the Registration form to the Health Safety Net Office within 30 days after making a payment to any Massachusetts Hospital or Ambulatory Surgical Center.

(b) Registered Payer List. The Health Safety Net Office will compile lists of registered Institutional Payers, and will update the lists quarterly. The Health Safety Net Office will distribute these lists to Hospitals and Ambulatory Surgical Centers upon request.

(c) Institutional Payers must register only once. A Registered Payer is automatically registered for the next Fiscal Year.

(4) Billing Process for Institutional Payers.

(a) Each Hospital and Ambulatory Surgical Center shall send a bill for the Health Safety Net surcharge to Surcharge Payers, as required by c.118G, § 38. Hospitals and Ambulatory Surgical Centers shall send this bill to Surcharge Payers from whom they have received payment for services in the most recent four quarters for which data is available. The bill will state the Surcharge Percentage. Hospitals and Ambulatory Surgical Centers shall send this bill to payers before September 1 of each Fiscal Year and before the effective date of any Surcharge Percentage.

(b) Each Hospital and Ambulatory Surgical Center shall also send a bill for the surcharge at the same time as the bill for services provided to Institutional Payers who have not registered with the Health Safety Net Office pursuant to 114.6 CMR 14.05(3)(a) and from whom they have received payment. The bill must be sent within 30 days of receiving the payment from the unregistered payer. The bill shall state the Surcharge Percentage, but not the dollar amount owed, and shall include notification of the surcharge payment process set forth below, as well as a registration form specified by the Health

Safety Net Office. Until the Hospital or Ambulatory Surgical Center receives the Registered Payer List, it shall send a bill for the surcharge at the same time as the bill for services provided to Institutional Payers which it did not already bill pursuant to 114.6 CMR 14.05(4)(a).

(5) Payment Process for Institutional Payers

(a) Monthly Surcharge Liability. After the end of each calendar month, each Institutional Payer shall determine the surcharge amount it owes to the Health Safety Net Trust Fund for that month. The amount owed is the product of the amount of payments subject to surcharge, as defined in 114.6 CMR 14.02, by the Surcharge Percentage in effect during that month. The Institutional Payer may adjust the surcharge amount owed for any surcharge over- or under-payments in a previous period.

1. Institutional 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 surcharge, must develop a reasonable method for allocating the portion of the payment intended to be used for services provided by Hospitals or Ambulatory Surgical Centers. Such Institutional Payers must file this allocation method by October 1 of each Fiscal Year. If there is a significant change in the global fee or capitation payment arrangement that necessitates a change in the allocation method, the Institutional Payer must file the new method with the Health Safety Net Office before the new payment arrangement takes effect. Institutional Payers may not change the allocation method later in the year unless there is a significant change in the payment arrangement.

a. The Health Safety Net Office will review allocation plans within 90 days of receipt. During this review period the Health Safety Net Office may require an Institutional Payer to submit supporting documentation or to make changes in this allocation method if it finds that the method does not reasonably allocate the portion of the global payment or capitation intended to be used for services provided by Hospitals or Ambulatory Surgical Centers.

b. An Institutional 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 surcharge.

2. An Institutional Payer must include all payments made as a result of settlements, judgments or audits in its determination of payments subject to surcharge. An Institutional Payer may include payments made by Massachusetts Hospitals or Ambulatory Surgical Centers to the Institutional Payer as a result of settlements, judgments or audits as a credit in its determination of payments subject to surcharge.

(b) Monthly Payments. Institutional Payers shall make payments to the Health Safety Net Trust Fund monthly. Each Institutional Payer shall remit the surcharge amount it owes to the Fund, determined pursuant to 114.6 CMR 14.05(5)(a), to the Health Safety Net Office for deposit in the Fund. Institutional Payers shall remit the surcharge payment by the first business

day of the second month following the month for which the surcharge amount was determined. For example, surcharge payments based on payments made to Hospitals and Ambulatory Surgical Centers in January are due by March 1.

(c) Biannual Surcharge Payment Option. An Ambulatory Surgical Center may request a biennial surcharge payment option if:

1. it has remitted 4 or fewer payments during the previous fiscal year:
2. it has remitted all required surcharge payments and submitted all monthly coupons;
3. it submitted a Surcharge Verification Form for the previous fiscal year; and
4. it has reported less than $10,000 in surcharge payments in the Surcharge Verification Form.

The Health Safety Net Office will notify payers eligible for the biannual option. The Payer may elect to receive biannual surcharge notices or to continue to receive monthly notices. Each biannual surcharge payment will equal (1) the appropriate surcharge percentage times (2) payments made to Massachusetts hospitals and ambulatory surgical centers for the prior six months.

(d) All surcharge payments must be payable in United States dollars and drawn on a United States bank. The Health Safety Net Office will assess a $30 penalty on any Surcharge Payer whose check is returned for insufficient funds.

(e) Any Institutional Payer, except Third Party Administrators, that has a surcharge liability of less than five dollars in any month or biannual payment period may delay payment until its surcharge liability is at least five dollars. For example, XYZ Company's surcharge liability for July is $3.50 and its liability for August is $2.00. XYZ Company may delay payment in July but must remit a check for $5.50 in August.

(6) Payment Process for Individual Payers (Self-pay). There is a surcharge on certain payments made by Individual Payers to Hospitals and Ambulatory Surgical Centers.

(a) Billing.

1. Hospitals and Ambulatory Surgical Centers shall include the surcharge amount on all bills to Individual Payers unless:
   a. the patient's liability is less than the individual payment threshold determined by the Health Safety Net Office. The individual payment threshold is a payment of $10,000 or more.
   b. the patient is a non-Massachusetts resident for whom the Hospital or Ambulatory Surgical Center can verify that the patient's family income would otherwise qualify the patient as a Low Income Patient under 114.6 CMR 13.04.
   c. the patient is approved for Medical Hardship in accordance with the requirements of 114.6 CMR 13.05. The bill shall direct Individual Payers to pay the surcharge to the Hospital or Ambulatory Surgical Center when making payment for services.
2. The amount of the surcharge billed is the product of (a) the patient's liability to the Hospital or Ambulatory Surgical Center, and (b) the Surcharge Percentage in effect on the billing date.

3. The amount of the surcharge owed by an Individual Payer is the product of (a) the total amount paid by the individual to a Hospital or Ambulatory Surgical Center; and (b) the Surcharge Percentage in effect on the payment date. Payments greater than or equal to the threshold received by Hospitals and Ambulatory Surgical Centers from Individual Surcharge Payers are subject to the surcharge.

(b) Hospitals and Ambulatory Surgical Centers must remit to the Health Safety Net Office the surcharge amount owed by Individual Payers for every payment greater than or equal to the threshold made by Individual Payers. If an Individual Payer makes separate payments over a twelve month period that are equal to or greater than the threshold and relate to an outpatient visit or inpatient stay, the surcharge amount due applies to the aggregate amount paid for the outpatient visit or inpatient stay. The first surcharge payment is due to the Health Safety Net Office when the total Individual Payer payment amount reaches the threshold.

(c) Hospitals and Ambulatory Surgical Centers shall remit such surcharge payments by the first business day of the second month following the month during which the surcharge was received. For example, surcharge payments received by Hospitals and Ambulatory Surgical Centers in January are due to the Pool on March 1. Hospitals and Ambulatory Surgical Centers may deduct collection agency fees for the collection of surcharge payments from Individual Payers from the total amount of surcharge payments forwarded to the Pool.

(d) All payments must be payable in United States dollars and drawn on a United States bank. The Health Safety Net Office will assess a $30 penalty on any Surcharge Payer whose check is returned for insufficient funds.

(e) If an embassy of a foreign government pays a Hospital or Ambulatory Surgical Center bill on behalf of an individual, the Provider may either: (a) bill the embassy for the individual's surcharge according to the billing and payment process for individual payers set forth in 114.6 CMR 14.05(6) or (b) bill the embassy according to the billing process for Institutional Payers as set forth in 114.6 CMR 14.05(4). If the Provider chooses to bill the embassy as an Institutional Payer and the embassy is not listed on the Registered Payer List, the Provider shall include the embassy on the Unmatched Payer Report and send surcharge payer registration information to the embassy.

(7) Penalties. If a Hospital, Ambulatory Surgical Center, or Surcharge Payer fails to forward surcharge payments pursuant to 114.6 CMR 14.05, the Health Safety Net Office shall impose an additional 1.5% interest penalty on the outstanding balance. The interest shall be calculated from the due date. For each month a payment remains delinquent, an additional 1.5% penalty shall accrue against the outstanding balance, including prior penalties.

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

(b) The Health Safety Net Office may reduce the penalty at the Health Safety Net Office's discretion. In determining a waiver or reduction, the Health Safety Net Office's consideration will include, but will not be limited to, the entity's payment history, financial situation, and relative share of the payments to the Uncompensated Care Pool.

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

(a) The Health Safety Net Office will review data submitted by Hospitals, Ambulatory Surgical Centers, and Institutional Payers pursuant to 114. CMR 14.08, the Surcharge Payer Registration forms submitted by Institutional Payers pursuant to 114.6 CMR 14.05(3)(a), and any other pertinent data. All information provided by, or required from, any Surcharge Payer, pursuant to 114.6 CMR 14.00 shall be subject to audit by the Health Safety Net Office. For surcharge payments based upon a global fee or capitation allocated according to an allocation method accepted by the Health Safety Net Office pursuant to 114.6 CMR 14.05(5)(a)(1), the Health Safety Net Office's review will be limited to determining whether this method was followed accurately and whether the amounts reported were accurate.

(b) The Health Safety Net Office may require the Surcharge Payer to submit additional documentation reconciling the data it submitted with data received from Hospitals.

(c) If the Health Safety Net Office determines through its review that a Surcharge Payer's payment to the Pool was materially incorrect, the Health Safety Net Office may require a payment adjustment. Payment adjustments shall be subject to interest penalties and late fees, pursuant to 114.6 CMR 14.05(7), from the date the original payment was owed to the Pool.

(d) Processing of Payment Adjustments.

1. Notification. The Health Safety Net Office shall notify a Surcharge Payer of its proposed adjustments. The notification shall be in writing and shall contain a complete listing of all proposed adjustments, as well as the Health Safety Net Office's explanation for each adjustment.

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

a. each adjustment to which the Surcharge Payer is objecting,
b. the Fiscal Year for each disputed adjustment,
c. the specific reason for each objection, and
d. all documentation that supports the Surcharge Payer's position.

3. Upon review of the Surcharge Payer's objections, the Health Safety Net Office shall notify the Surcharge Payer of its determination in writing. If the Health Safety Net Office disagrees with the Surcharge Payer's objections, in whole or in part, the Health Safety Net Office shall provide the Surcharge Payer with an explanation of its reasoning.

4. The Surcharge Payer may request a conference on objections after receiving the Health Safety Net Office's explanation of reasons. The Health Safety Net Office will schedule such conference on objections only when it believes that further articulation of the Surcharge Payer's position is beneficial to the resolution of the disputed adjustments.

(e) Payment of Adjustment Amounts. Adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Notification letter. If the Surcharge Payer submitted a written

objection, then adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Health Safety Net Office's determination. The Health Safety Net Office may establish a payment schedule for adjustment amounts.

14.06 Payments to Hospitals.

(1) General Provisions.

(a) The Health Safety Net Office will pay Hospitals based on claims in accordance with the requirements of 114.6 CMR 13.00.

1. The Health Safety Net Office will monitor the volume of claims submitted and may adjust or withhold payments if it appears that there has been a substantial change in the Provider's service delivery patterns and/or billing activity, including, but not limited to, unbundling of services, upcoding, or other billing maximization activities.

2. If the Provider submitted Term Bills to the Uncompensated Care Pool or the Health Safety Net during Fiscal Year 2006 and Fiscal Year 2008, it must continue to submit Term Bills for Fiscal Year 2009.

(b) Payment Types. The Health Safety Net Office will calculate Health Safety Net payments for each Hospital for the following categories of claims for which the Health Safety Net is the primary payer:

Inpatient - Medical
Inpatient - Psychiatric
Inpatient - Rehabilitation
Outpatient
Emergency Bad Debt - Inpatient Medical
Emergency Bad Debt - Inpatient Psychiatric
Emergency Bad Debt - Outpatient

The Health Safety Net Office will also establish payments for inpatient claims for which the Health Safety Net is the secondary payer. The Health Safety Net Office will reduce payments by the amount of co-payments and deductibles required by 114.6 CMR 13.00, Emergency Bad Debt recoveries, and investment income on free care endowment funds. The Health Safety Net Office will determine the offset of free care endowment funds by allocating free care endowment income between Massachusetts residents and non-residents using the best data available and offsetting the Massachusetts portion against Health Safety Net claims.

(c) Method of Payment. The Health Safety Net Office may make payments to Hospitals for Eligible Services through a safety net care payment under the Massachusetts Section 1115 Demonstration Waiver, a MassHealth supplemental hospital rate payment, or a combination thereof. The Health Safety Net Office may limit a Hospital's Payment for Eligible Services to comply with requirements under the Massachusetts Section 1115 Demonstration Waiver governing safety net care, or any other federally required limit on payments under 42 U.S.C. § 1396a(a)(13) or 42 CFR 447.

(d) Data Sources. The Health Safety Net Office will use the following Medicare payment data sources to determine Inpatient Payments. Unless

otherwise specified, the Health Safety Net Office will use values established by CMS. The Division will update these values as needed to conform with changes implemented by the Medicare program during FY2009:

1. DRG Weight. The Version 26 Medicare severity diagnostic related group (MS-DRG) weight for a particular MS-DRG as published in the *Federal Register*.

2. DSH Factor. The hospital-specific operating and capital factors calculated pursuant to 42 CFR 412.106. For hospitals classified by CMS as Pickle Hospitals, the DSH factor for operating expenses is 0.35 and the DSH factor for capital expenses is 0.125.

3. Geographic Adjustment Factor (GAF). The GAF varies by hospital and is the Medicare wage index raised to 0.6848 pursuant to 42 CFR 412.316(a).

4. Indirect Medical Education (IME) Adjustment. A hospital-specific CMS adjustment to the Medicare payment calculated pursuant to 42 CFR 412.105.

5 Pass through add-on. A hospital-specific CMS adjustment to the Medicare payment.

6. Standardized Amount – Labor. $3,574.50, the FY2009 amount for hospitals with wage indices above 1.0, as published by CMS on September 29, 2008.

7. Standardized Amount – Non-Labor. $1,553.91, the FY2009 amount for hospitals with wage indices above 1.0, as published by CMS on September 29, 2008.

8. Standardized Capital Amount. $424.17, the FY2009 amount as published by CMS on September 29, 2008.

9. Wage Index. The hospital-specific wage index used to determine Medicare payments.

(2) Payments for Inpatient Services. The Health Safety Net Office will pay hospitals in accordance with Medicare FY2009 Inpatient Prospective Payment System (IPPS) for non-psychiatric claims, and the Inpatient Psychiatric Facility Prospective Payment System (IPF-PPS) for psychiatric claims. Hospitals classified by Medicare as Critical Access Hospitals (CAHs), PPS-Exempt Hospitals, Medicare Dependent Rural Hospitals, and Sole Community Hospitals will be paid in accordance with 114.6 CMR 14.06(2)c.

(a) Inpatient Medical Payment - Standard.

1. Calculation of the HSN Medical Inpatient Payment. For all Hospitals except Medicare-designated Critical Access Hospitals, PPS-Exempt Hospitals, Sole Community Hospitals and Medicare Dependent Rural Hospitals, the Health Safety Net Office will calculate an Inpatient Medical Payment as follows:

a. Adjusted Standard Amount (ASA). The ASA equals:

(Standard Labor Amount*Wage Index) + (Standard Non-Labor Amount)

b. DRG weight. The DRG weight is determined on a per claim basis using the Medicare version 26 MS-DRG grouper.

c. Operating DRG Payment. The Operating DRG Payment equals:

ASA*DRG Weight*(1+DSH Operating Factor)*(1+IME Operating Factor)

d. Capital DRG Payment. The Capital DRG Payment equals:

(Standard Capital Amount)*DRG Weight*GAF*
(1+DSH Capital Factor)*(1+IME Capital Factor)

e. Pass through Payment: The Pass through Payment equals:

Pass through per diem*length of stay

f. Outlier Payment. The Health Safety Net Office will calculate an additional outlier payment for qualifying cases. A case qualifies for an outlier payment if the estimated case cost exceeds the outlier threshold. The estimated case cost is determined by discounting total charges, less hospital-based physician charges, by a cost to charge ratio. The fixed outlier threshold is $20,045, adjusted for the hospital-specific wage index, DSH, IME, and GAF amounts. The total outlier payment is the marginal cost factor of 80% of the difference between the estimated cost and the outlier threshold

g. Inpatient Medical Payment. The hospital-specific total case payment for each discharge is the sum of the Operating DRG Payment, the Capital DRG Payment and the Pass through Payment. It may be further adjusted, as applicable, by an Outlier Payment, or adjustment under 114.6 CMR 14.06(2)(b).

(b) Adjustments to Inpatient Medical Payment.

1. Transfer Case Payments. If a case qualifies as a transfer case under Medicare rules, the Health Safety Net Office will calculate a per diem rate, capped at the full discharge payment. The per diem rate is the hospital-specific DRG payment calculated under 114.6 CMR 14.05(2)(b) (1)(e), divided by the length of stay for the DRG. For qualifying cases, transfer payments may also include a per diem outlier payment.
2. Special Pay Post-Acute DRGs. If a case would qualify as a “special pay DRG” under Medicare rules, the Health Safety Net Office will calculate a rate as follows: Day 1 is set at 50% of the full DRG payment, plus a single transfer payment per diem. Subsequent days are set at 50% of the transfer per diem. In no case will the calculated payment exceed the full DRG payment. For qualifying cases, special pay post-acute DRGs may also include a per diem outlier payment.
3. Partially-eligible stays. If a patient is eligible for the Health Safety Net for part of an inpatient stay, the hospital will receive the transfer

per diem rate for the number of eligible inpatient days, not to exceed the full discharge payment.

(c) Inpatient Medical Payment - Other Hospitals

1. Critical Access Hospitals. The Health Safety Net Office will calculate a per discharge payment for all discharges occurring at Medicare Critical Access Hospitals as follows:

a. The Division will determine the average charge per discharge using FY2008 adjudicated and eligible HSN claims data as of June 27, 2008.

b. The Division will determine an average cost per discharge by multiplying the average charge per discharge by an inpatient cost to charge ratio using FY2007 HCF-403 data.

c. The average cost per discharge will be increased by a cost adjustment factor of 1.0404, and an additional factor of 1.01. The product of this calculation is the per discharge payment applicable to all discharges occurring in FY2009, except that partially eligible stays will be paid pursuant to 114.6 CMR 14.06(2)(b)3.

2. PPS-Exempt Hospitals. The Health Safety Net Office will calculate a per discharge payment for all discharges occurring at PPS-exempt cancer and Pediatric Hospitals as follows:

a. The Division will determine the average charge per discharge using FY2008 adjudicated and eligible HSN claims data as of June 27, 2008.

b. The Division will determine an average cost per discharge by multiplying the average charge per discharge by an inpatient cost to charge ratio using FY2007 HCF-403 data.

c. The average cost per discharge will be increased by a cost adjustment factor of 1.0404. The product of this calculation is the per discharge payment applicable to all discharges occurring in FY2009, except that partially eligible stays will be paid pursuant to 114.6 CMR 14.06(2)(b)3.

3. Sole Community Hospitals. The Health Safety Net Office will calculate a hospital-specific per discharge amount for Hospitals classified by Medicare as Sole Community Hospitals, rather than the Adjusted Standardized Amount. This amount is based on the hospital-specific rate provided by the Medicare fiscal intermediary, adjusted for inflation. The payments may include transfer, outlier, and special pay amounts, using the hospital-specific rate in these calculations, for qualifying cases. Partially eligible stays will be paid pursuant to 114.6 CMR 14.06(2)(b)3.

4. Medicare Dependent Rural Hospitals. The Health Safety Net Office will calculate a will receive a blended payment consisting of 75% of a hospital-specific payment and 25% of the Operating DRG Payment for Hospitals classified by Medicare as Medicare Dependent Rural Hospitals The payments may include transfer, outlier, and special pay amounts, using the hospital-specific blended rate in these calculations, for qualifying cases. Partially eligible stays will be paid pursuant to 114.6 CMR 14.06(2)(b)(4).

(d) Inpatient Psychiatric Payment.

1. Psychiatric Case. A case is classified as psychiatric if

a. the Hospital has a Medicare psychiatric unit;
b. the primary diagnosis is related to a psychiatric disorder with an ICD-9 code beginning with 29, 30 or 31; and
c. the claim includes psychiatric accommodation charges.

2. Psychiatric Payment. The Health Safety Net Office will calculate a per diem payment as follows:

a. Base Rate. The Adjusted Rate equals:

(Labor share of the Medicare Federal Per Diem psychiatric rate,
$482.36*Wage Index) +
(Non-labor share of the Medicare Federal Per Diem, $155.42)

3. Teaching Adjustment. There is an additional teaching adjustment for Hospitals with Medicare approved teaching programs. The teaching adjustment equals:

$$(1+ (\text{number of psych resident FTEs/Average daily census})^{**0.5150})$$

4. Other Adjustments. Other adjustments will be included in the payment rate in accordance with the Medicare payment provisions identified in the May 7, 2008 *Federal Register*. These include adjustments for specific DRGs, the presence of comorbidities, patient age, and length of stay.

5. Outlier Payments. Additional outlier payments will be included in the payment rate for qualifying cases that exceed the outlier threshold. Outlier payments are calculated as follows:

a. Outlier Threshold. The psychiatric outlier threshold is the fixed threshold adjusted for the hospital's wage index, plus the psychiatric payment calculated above.
b. Outlier Per Diem. The outlier per diem is the difference between the psychiatric case costs estimated using the cost to charge ratio and the outlier threshold, divided by the length of stay.
c. Outlier Payment. If the length of stay is less than or equal to 9 days, the additional outlier payment is 80% of the outlier per diem times the length of stay. For Day 9 and additional days, the outlier payment is 60% of the outlier per diem.

6. Total Case Payment. The total case payment is the sum of the base payment, teaching adjustment, other adjustments, and outlier payments.

(e) Inpatient Rehabilitation Payment.

1. Rehabilitation Case. A case is classified as rehabilitation if:

a. the Hospital has a Medicare rehabilitation unit; and
b. the claim includes rehabilitation accommodation charges.

2. Payment. Rehabilitation cases are paid on a per diem basis. The payment is determined using the Hospital's most recently filed CMS-2552 Cost Report. The rate is the sum of total rehabilitation PPS

payments and reimbursable bad debts, divided by total rehabilitation days.

(f) Physician Payments.

1. The Health Safety Net Office will calculate payments for hospital-based physician services provided to inpatients by multiplying the billed charges by the payment on account factor calculated pursuant to 114.6 CMR 14.06(3).

2. Effective January 1, 2009, the Health Safety Net Office will calculate payments for hospital-based physician services provided to inpatients using the Medicare fee schedule.

(g) Hospital-Acquired Conditions.

1. All hospitals, including but not limited to PPS-Exempt Hospitals, are required to report the Present on Admission indicator for all diagnosis codes on inpatient claims.

2. The Health Safety Net Office will not assign an inpatient case to a higher paying MS-DRG if a Hospital-Acquired Condition that was not present on admission occurs during the stay. For hospital services paid pursuant to 114.6 CMR 14.06(2)(a) and (b), the DRG payment will be reduced in accordance with Medicare principles.

(h) Serious Reportable Events. The Health Safety Net Office will not pay for services related to Serious Reportable Events as defined by the National Quality Forum. The Office may issue Administrative Bulletins clarifying billing requirements and payment specifications for these Events.

(3) Payments for Outpatient Services. The Health Safety Net Office will pay a per visit amount for each outpatient visit. An outpatient visit includes all outpatient services, including hospital-based physician services, provided in a single day, except for dental services. The outpatient per visit amount is determined as follows:

(a) For each hospital, the Division will calculate an average outpatient charge per visit, using FY2008 adjudicated and eligible Health Safety Net claims as of June 27, 2008. Charges for dental claims and charges for outpatient claims within 72 hours of an inpatient admission will be excluded. For Critical Access Hospitals and PPS-Exempt Hospitals, only charges for claims within 24 hours of an inpatient admission will be excluded.

(b) The Division will determine an outpatient payment per visit by multiplying the average outpatient charge per visit by a Medicare Payment on Account Factor, calculated using the best available data and subject to review and adjustment by the Division. This product is further increased by a cost adjustment factor of 4.04%.

(c) Disproportionate Share Hospitals and non-teaching Hospitals will receive a transitional add-on of 25% of the outpatient per visit payment rate.

(d) The payment for PPS-exempt Pediatric and cancer Hospitals and Medicare Critical Access Hospitals will be determined using the ratio of costs to charges from the FY 2007 HCF-403 cost report.

(4) Dental Services. The Health Safety Net Office will pay hospitals for dental services provided at hospitals and hospital-licensed health centers using the fees established in 114.3 CMR 14.00: Dental Services. No additional outpatient per visit payment will be paid for dental services.

(5) Hospital Outpatient Pharmacies.

(a) Prescribed Drugs. For Hospitals with outpatient pharmacies, the Health Safety Net Office will pay for prescribed drugs using rates set forth in 114.3 CMR 31.00. The payment will be reduced by the amount of patient cost-sharing set forth in 114.6 CMR 13.00. Claims will be adjudicated by the MassHealth Pharmacy Online Payment System.
(b) Part B Covered Services. Medical supplies normally covered by the Medicare Part B program that are dispensed by Hospital outpatient pharmacies that are not Part B providers will be paid at 20% of the rates set forth in 114.3 CMR 22.00 and 114.3 CMR 31.00.

(6) Secondary Payer. The Health Safety Net Office will pay claims for which it is not the primary payer as follows:
(a) Medicare as primary payer. For any allowable claim for which Medicare is the primary payer, the Health Safety Net Office will pay the amount of the patient deductible or co-insurance.
(b) Other primary payers. For any allowable claim for which a payer other than Medicare is the primary payer. For allowable claims for which the Health Safety Net is the secondary payer, the payment is the product of the net billed charges and the Medicare Payment on Account Factor.

(7) Bad Debt Payments. The Health Safety Net Office will calculate Emergency Bad Debt payments for Inpatient Medical, Psychiatric, and Outpatient Services, using the methodology in 114.6 CMR 14.06 (2) and (3), except that the Emergency Bad Debt outpatient rate does not include the transitional add-on cited in 114.6 CMR 14.06(3)(c).

(8) Other. The Health Safety Net Office will make an additional payment of $3.85 million for freestanding pediatric hospitals. The Health Safety Net Office may make an additional payment adjustment for the two Disproportionate Share Hospitals with the highest relative volume of free care costs in FY 2006.

(9) Transition Payments. The Health Safety Net Office will make monthly Transition Payments to Hospitals for the months of October 2008 through January 2009. Each Hospital will be paid the average of two payment bases: adjudicated monthly claims using a date of service basis and adjudicated claims using a date of submission basis. These payment bases will exclude remediated FY2008 claims as defined in 114.6 CMR 14.06(9)(d).
(a) Date of Service Basis. The Office will determine the total payment amounts for Primary and Bad Debt claims according to the following schedule:

Payment Cycle Month	Primary and secondary claims, with existing HSN eligibility	Pharmacy claims	Bad Debt claims
October 2008	Claims with dates of service between April 1, 2008 – April 30, 2008	Claims with dates of service between June 1, 2008 and June 30, 2008	Written off during April 2008

November 2008	Claims with dates of service between May 1, 2008 and May 31, 2008	Claims with dates of service between July 1, 2008 and July 31, 2008	Written off during May 2008
December 2008	Claims with dates of service between June 1, 2008 and June 30, 2008	Claims with dates of service between August 1, 2008 and August 31, 2008	Written off during June 2008
January 2009	Claims with dates of service between July 1, 2008 and July 31, 2008	Claims with dates of service between September 1, 2008 and September 30, 2008	Written off during July 2008

(b) Date of Submission basis. The Office will determine the total payment amounts for Primary and pharmacy claims according to the following schedule:

Payment Cycle Month	Primary secondary and pharmacy claims	Bad Debt Claims
October 2008	Eligible claims submitted during August 2008	Written off during August 2008
November 2008	Eligible claims submitted during September 2008	Written off during September 2008
December 2008	Eligible claims submitted during October 2008	Written off during October 2008
January 2009	Eligible claims submitted during November 2008	Written off during November 2008

(c) For the payment cycle months of October 2008 through January 2009, the payment will be the average of the amounts determined pursuant to 114.6 CMR 14.06(9)(a) and 114.6 CMR 14.06(9)(b),.
(d) FY2008 Remediated Claims. FY2008 Remediated_Claims include claims with dates of service prior to April 1, 2008 that were previously denied or paid, but, due to hospital resubmission or Division action, were remediated and paid or voided in the payment cycle months of October 2008 through January 2009. The Division will price these claims, multiply the total value of the priced claims by a factor of 2, to treat these claims consistently with the payment basis for FY2008, and include this amount in hospital payments for the payment cycles of October 2008 through January 2009. Any

FY2008 claim remediated after the January 31, 2009 will be paid as priced, without the additional factor of 2

(10) Basis of Payment. For the monthly payment cycles beginning with February 2009, payments will be made using claims submitted for two months prior to the payment cycle month.

14.07 Payments to Community Health Centers

(1) General Provisions.

(a) The Health Safety Net Office will pay Community Health Centers based on claims submitted to the Office, less applicable cost sharing amount, in accordance with the requirements of 114.6 CMR 13.00 and claims specifications determined by the Office. The Health Safety Net Office will monitor the volume of claims submitted and may adjust or withhold payments if it appears that there has been a substantial change in the Provider's service delivery patterns, including, but not limited to, unbundling of services, upcoding, or other billing maximization activities.

(b) The Health Safety Net Office will pay a Community Health Center for prescribed drugs only if the Center is also providing prescribed drugs to MassHealth members and receiving payment from MassHealth according to 114.3 CMR 31.07.

(2) Payments for Services. Except for claims for Urgent Bad Debt, the Health Safety Net Office will pay Community Health Centers as follows:

Service	*Codes*	*Payment*
Medical Visit	CPT Evaluation and Management codes for on-site services and certain hospital visits	100% Medicare FQHC rate; limit one visit per day
Medical Visit - Urgent Care	Code 99051	Rate for 99050 in 114.3 CMR 4.00
Surgical Procedure (provided on a day separate from a Medical Visit)	CPT surgery codes clinically appropriate for office setting	100% of Medicare FQHC rate
Cardio and Pulmonary Diagnostic (technical component only)	Cardiovascular (93000 series) and Pulmonary (94000 series)	114.3 CMR 17.00
Obstetrical Services	Global OB codes	114.3 CMR 16.00
Behavioral Health (diagnostic)	CPT Behavioral Health Diagnostic codes; CHC licensed services	100% Medicare FQHC rate
Behavioral Health (treatment)	CPT Behavioral Health Treatment codes	62.5% Medicare FQHC rate for hourly individual treatment; 31.25% of Medicare FQHC rate for 30 minute codes except group codes; for group treatment and medication visit, rates in 114.3 CMR 6.00
Radiology	Applicable CPT Code	114.3 CMR 18.00
Clinical Laboratory	CPT Lab Codes	114.3 CMR 20.00
Dental	CDT - HCPC - D codes D9450 (case presentation - CHC enhancement)	114.3 CMR 14.00; payment for Code D9450 in 114.3 CMR 4.00
340B Pharmacy	MassHealth Pharmacy On-Line Payment System	114.3 CMR 31.00; $3 co-pay brand; $1 co-pay generic
Vision Care (diagnostic)	Exam, diagnostic tests	100% Medicare FQHC rate for all inclusive visit; limit one visit per day
Vision Care (dispensing, repair)	V-codes glasses; fitting/dispensing/repair	114.3 CMR 15.00
Medical Nutrition Therapy	MassHealth identified codes	114.3 CMR 17.00
Diabetes Self -Management Treatment	MassHealth identified codes	114.3 CMR 17.00
Tobacco Cessation Services	MassHealth identified codes	114.3 CMR 17.00
Preventative Services/Risk Factor Reduction	99402	114.3 CMR 12.00
Immunization visits	90471-90473	114.3 CMR 17.00
Vaccines not included in the Medical Visit or supplied by DPH	CPT codes	114.3 CMR 17.00

(3) Urgent Care Bad Debt Payments. The Health Safety Net Office will pay Community Health Centers at 75% of the payment rates in 114.6 CMR 14.07 (2) for Urgent Care Bad Debt claims that meet the requirements in 114.6 CMR 13.00.

14.08 Reporting Requirements

(1) General. Each Provider, Surcharge Payer and Ambulatory Surgical Center shall file or make available information that is required or that the Health Safety Net Office deems reasonably necessary for implementation of 114.6 CMR 14.00.

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

(b) The Health Safety Net Office may audit data submitted under 114.6 CMR 14.00 to ensure accuracy. The Health Safety Net Office may adjust payments to reflect audit findings. Providers must maintain records sufficient to document compliance with all documentation requirements of 114.6 CMR 13.00 and 114.6 CMR 14.00.

(2) Hospitals

(a) The Health Safety Net Office may require Hospitals to submit interim data on revenues and costs to monitor compliance with federal Upper Limit and Disproportionate Share payment limits. Such data may include, but not be limited to, Gross and Net Patient Service Revenue for Medicaid non-managed care, Medicaid managed care, and all payers combined; and total patient service expenses for all payers combined.

(b) Surcharge Payment Data.

1. Unmatched Payer Report. Each Hospital must submit a quarterly Unmatched Payer Report. The Hospital must report the total amount of payments for services received from each Institutional Payer that does not appear on the Registered Payer List. The Hospital must report these data in an electronic format specified by the Health Safety Net Office.

2. Quarterly Report for Private Sector Payments. Each Hospital must report total payments made by the largest Institutional Surcharge Payers. The Health Safety Net Office will specify: the Institutional payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Health Safety Net Office may modify the reporting requirements from time to time by administrative bulletin.

(c) Penalties. The Health Safety Net Office may deny payment for Eligible Services to any Hospital that fails to comply with the reporting requirements of 114.6 CMR 13.00 or 114.6 CMR 14.00 until such Hospital complies with the requirements. The Health Safety Net Office will notify such Hospital in advance of its intention to withhold payment.

(3) Community Health Centers. The Health Safety Net Office may deny payment for Eligible Services to any Community Health Center that fails to comply with the reporting requirements of 114.6 CMR 13.00 or 114.6 CMR 14.00 until such Center

complies with the requirements. The Health Safety Net Office will notify such Center in advance of its intention to withhold payment.

(4) Surcharge Payers.

(a) Monthly Surcharge Payment Report. The Health Safety Net Office may require that an Institutional Payer submit monthly reports of payments to Hospitals and Ambulatory Surgical Centers.

(b) Third Party Administrators.

1. A Third Party Administrator Surcharge Payer that makes payments to Hospitals and Ambulatory Surgical Centers on behalf of one or more insurance carriers must file an annual report with the Health Safety Net Office. The report shall include the name of each insurance carrier for which it makes surcharge payments. The Health Safety Net Office may also specify additional reporting requirements concerning payments made on behalf of self insured plans. Reports shall be in an electronic format specified by the Health Safety Net Office.

2. Third Party Administrators must submit annual reports by July 1 of each year for the time period defined by the Health Safety Net Office.

(c) Penalties. Any Surcharge Payer that fails to file data, statistics, schedules, or other information pursuant to 114.6 CMR 14.08 or which falsifies same, shall be subject to a civil penalty of not more than $5000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction. The Attorney General shall bring any appropriate action, including injunction relief, as may be necessary for the enforcement of the provisions of 114.6 CMR 14.00.

(5) Ambulatory Surgical Centers

(a) Unmatched Payer Report. Each Ambulatory Surgical Center must submit a Quarterly Unmated Payer Report to the Health Safety Net Office in accordance with a schedule specified by the Health Safety Net Office. The Ambulatory Surgical Center must report the total amount of payments for services received from each Institutional Surcharge Payer that does not appear on the Registered Payer List. The Ambulatory Surgical Center must report these data in an electronic format specified by the Health Safety Net Office.

(b) Quarterly Report for Private Sector Payments. Each Ambulatory Surgical Center must report total payments made by the largest Institutional Surcharge Payers. The Health Safety Net Office will specify the Institutional Payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Health Safety Net Office may modify the reporting requirements from time to time by administrative bulletin.

(c) Penalties. An Ambulatory Surgical Center that knowingly fails to file with the Health Safety Net Office any data required by 114.6 CMR 14.03 or knowingly falsifies the same shall be subject to a $500.00 fine.

14.09: Special Provisions

(1) Financial Hardship. A Hospital or Surcharge Payer may request a deferment or partial payment schedule due to financial hardship.

(a) In order to qualify for such relief, the Hospital or Surcharge Payer must demonstrate that its ability to continue as a financially viable going concern will be seriously impaired if payments pursuant to 114.6 CMR 14.04 or 114.6 CMR 14.05 were made.
(b) If the Health Safety Net Office finds that payments would be a financial hardship, the Health Safety Net Office may, at its discretion, establish the terms of any deferment or partial payment plan deferment. The deferment or payment schedule may include an interest charge.

1. The interest rate used for the payment schedule shall not exceed the prime rate plus 2%. The prime rate used shall be the rate reported in the *Wall Street Journal* dated the last business day of the month preceding the establishment of the payment schedule.
2. A Surcharge Payer may make a full or partial payment of its outstanding liability at any time without penalty.
3. If a Surcharge Payer fails to meet the obligations of the payment schedule, the Health Safety Net Office may assess penalties pursuant to 114.6 CMR 14.05.

(2) Severability. The provisions of 114.6 CMR 14.00 are severable. If any provision or the application of any provision to any Hospital, Community Health Center, surcharge payer or Ambulatory Surgical Center or circumstances is held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.6 CMR 14.00 or the application of such provisions to Hospitals, Community Health Centers or circumstances other than those held invalid.

(3) Administrative Bulletins. The Health Safety Net Office may issue administrative bulletins to clarify policies and understanding of substantive provisions of 114.6 CMR 14.00 and specify information and documentation necessary to implement 114.6 CMR 14.00.

REGULATORY AUTHORITY

114.6 CMR 14.00 M.G.L. c. 118G.