958 CMR 2.00: ONE-TIME ASSESSMENT ON CERTAIN QUALIFYING HOSPITALS AND QUALIYFING SURCHARGE PAYORS

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2.01: General Provisions

(1) Scope, Purpose and Effective Date. 958 CMR 2.00 governs payments to the Health Policy Commission from certain Acute Hospitals and Surcharge Payors.

(2) Authority: 958 CMR 2.00 is adopted pursuant to St. 2012, c. 224, § 241 and M.G.L. c. 6D.

2.02: Definitions

Meaning of Terms: As used in 958 CMR 2.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 958 CMR 2.00 are capitalized.

Acute Hospital. The teaching hospital of the University of Massachusetts Medical School and any hospital licensed under M.G.L. c. 111, § 51 and which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public health.

Acute Hospital System. A group of affiliated entities that includes one or more Acute Hospitals that are overseen by a common entity or parent corporation.

Commission. The Health Policy Commission established under M.G.L. c. 6D.

Commonwealth Care Program. An insurance program for low-income individuals administered by the Commonwealth Health Insurance Connector pursuant to M.G.L. c. 118H.

Executive Office. The Executive Office of Health and Human Services established under M.G.L. c. 6A

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

Health Care Services. Supplies, care and services of medical, behavioral health, substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital care and services; services provided by a community health center home health and hospice care provider, or by a sanatorium, as included in the definition of "hospital" in Title XVIII of the federal Social Security Act, and treatment and care compatible with such services or by a health maintenance organization.

Hospital. A hospital licensed under M.G.L. c. 111, § 51, the teaching hospital of the University of Massachusetts Medical School and any psychiatric facility licensed under M.G.L. c. 19, § 19.

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.

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 § 1115 Demonstration Waiver.

Qualifying Hospital. An Acute Hospital that, as of fiscal year 2010, meets one of the following criteria as determined by the Commission using the best data available:

(a) has more than $1,000,000,000 in total net assets and receives less than 50 % revenues from public payers; or

(b) is a member of an Acute Hospital System that has more than $1,000,000,000 in total net assets and receives less than 50 % revenues from public payers.

Qualifying Surcharge Payor. A Surcharge Payor which, as determined by the Commission using the best data available, made payments to the Health Safety Net during fiscal year 2012 for the purchase of at least $1,000,000 in Hospital Services.

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.

Surcharge Payor. 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, including a managed care organization. The term "Surcharge Payor" 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.

2.03: Acute Hospital Assessment

(1) General. The Commission shall establish a one-time surcharge assessment on all Qualifying Hospitals. The surcharge amount to be paid to the Commission by each Qualifying Hospital is the product of:
(a) $60,000,000; and
(b) the hospital surcharge percentage as defined in 958 CMR 2.03 (2).

(2) Calculation of the Hospital Surcharge Percentage. The Commission shall establish the hospital surcharge percentage, using the best data available as determined by the Commission, by dividing the operating surplus in fiscal year 2010 by the total operating surplus in fiscal year 2010 of all Qualifying Hospitals.

(3) Payment Process.
(a) Notification. The Commission shall notify all Qualifying Hospitals of its total surcharge amount by April 1, 2013. The notification shall be in writing and shall inform the hospital of its payment options as defined by 958 CMR 2.03 (3)(b) and the option to apply for a waiver or mitigation pursuant to 958 CMR 2.03(4) and (5).
(b) Payment Option. A Qualifying Hospital shall pay the full amount of the surcharge amount to the Commission in the following manner:
1. A single payment to be made no later than June 30, 2013; or,
2. In 4 equal annual installments to be paid on or before June 30th of each year beginning on June 30, 2013.
(c) All surcharge payments must be payable in United States dollars and drawn on a United States bank. The Commission will assess a $30 penalty on any Qualifying Hospital whose check is returned for insufficient funds.

(4) Hospital Waiver. A Qualifying Hospital may apply to the Commission for a waiver of its total surcharge amount. In order to be considered for such relief, the Qualifying Hospital must demonstrate to the satisfaction of the Commission that it, or the Acute Hospital System for which the Qualifying Hospital is a member, lacks access to the resources to pay the surcharge amount using the factors set for the in 958 CMR 2.03(4)(b).
(a) Waiver Application. A Qualifying Hospital shall file its application for a waiver with the Commission within 21 calendar days of the date of the notice from the Commission pursuant to 958 CMR 2.03 (3)(a). Applications received after 21 calendar days of the date of the notice

from the Commission pursuant to 958 CMR 2.03 (3)(a) shall not be accepted by the Commission.

(b) Waiver Application Determination. The Commission shall take the following factors into account when determining whether to approve or disapprove a waiver application submitted by a Qualifying Hospital:

1. Cash and investments on hand;
2. Total cash and investments;
3. Total revenues;
4. Total reserves;
5. Total profits, margins or surplus;
6. Earnings before interest;
7. Depreciation and amortization;
8. Administrative expense ratio; and,
9. The compensation of executive managers and board managers.

(c) Supplemental Information. A Qualifying Hospital shall file or make available any information that the Commission deems reasonably necessary for evaluation of a waiver application.

(5) Hospital Mitigation.

(a) Qualifying Hospital may apply to the Commission for mitigation of up to 66 % of its total surcharge amount. In order to be considered for such relief, the Qualifying Hospital must first demonstrate to the satisfaction of the Commission that it meets one of the following criteria:

1. Receives more than 25 % of its reimbursements from Title XIX of the Social Security Act;
2. Is a member of an Acute Hospital System that receives more than 25 % of its reimbursements from Title XIX of the Social Security Act;
3. Has less than $1,250,000,000 in net assets; or,
4. Is a member of an Acute Hospital System that has less than $1,250,000,000 in net assets.

(b) Mitigation Application. A Qualifying Hospital shall file its application for partial mitigation with the Commission within 21 calendar days of the date of the notice from the Commission pursuant to 958 CMR 2.03 (3)(a). Applications shall demonstrate that the Qualifying Hospital meets one or more of the mitigation criteria set forth in 958 CMR 2.03(5). Applications received after 21 calendar days of the date of the notice from the Commission pursuant to 958 CMR 2.03 (3)(a) shall not be accepted by the Commission.

(c) Mitigation Application Determination. The Commission shall make a determination on a mitigation application.

(d) Supplemental Information. A Qualifying Hospital shall file or make available any information that the Commission deems reasonably necessary for evaluation of a mitigation application.

2.04: Surcharge Payor Assessment

(1) General. The Commission shall establish a one-time surcharge assessment on all Qualifying Surcharge Payors. The surcharge amount to be paid to the Commission by each Qualifying Surcharge Payor is the product of:
(a) $165,000,000; and
(b) the surcharge payor surcharge percentage as defined in 958 CMR 2.04(2).

(2) Calculation of the Surcharge Payor Surcharge Percentage. The Commission shall establish, using the best data available as determined by the Commission, the surcharge payor surcharge percentage by dividing the surcharge payor's payments made to the Health Safety Net during fiscal year 2012 for Hospital Services by the total of such payments from all surcharge payors in fiscal year 2012.

(3) Payment Process for Surcharge Payors
(a) Notification. The Commission shall notify all Qualifying Surcharge Payors of its total surcharge amount by April 1, 2013. The notification shall be in writing and shall inform the Surcharge Payor of its payment options as defined by 958 CMR 2.04 (3)(b).
(b) Payment Option. A Qualifying Surcharge Payor shall pay the full amount of the surcharge amount to the Commission in the following manner:
1. A single payment to be made no later than June 30, 2013; or,
2. In four equal annual installments to be paid on or before June 30th of each year beginning on June 30, 2013.
(c) All surcharge payments must be payable in United States dollars and drawn on a United States bank. The Commission will assess a $30 penalty on any Surcharge Payor whose check is returned for insufficient funds.

2.05: Distribution of Funds

(1) General. Revenue collected by the Commission under 958 CMR 2.03 and 958 CMR 2.04 shall be immediately distributed by the comptroller in the following manner:
(a) 5 % of all revenue collected shall first be transferred to the Health Care Payment Reform Fund, established under St. 2011, c. 194 § 100.
(b) The remaining revenue shall be distributed in the following manner:
1. 60 % shall be transferred to the Distressed Hospital Trust Fund, established under M.G.L. c. 29, § 2GGGG;
2. 26 $^{2/3}$ % shall be transferred to the Prevention and Wellness Trust Fund, established under M.G.L. c. 111, § 2G ; and

3. $13^{1/3}$ % shall be transferred to the e-Health Institute Fund, established under M.G.L. c. 40J, § 6E.

(2) Waiver or Mitigation Adjustment. If the Commission grants a waiver or mitigation of any payment amounts under 958 CMR 2.03, the Commission shall adjust the distribution of collected funds to ensure that the total amount waived or mitigated is reduced from the amount to be deposited in the Distressed Hospital Trust Fund only.

2.06: Penalties

(1) Late Payment Penalty. If a Qualifying Hospital or Qualifying Surcharge Payor fails to make a scheduled payment pursuant to 958 CMR 2.03 and 2.04, the Commission shall impose an additional 2.5% interest penalty on the outstanding balance. The interest shall be calculated from the due date option selected under 958 CMR 2.03(3)(b) or 2.04(3)(b), whichever applies. For each 30 calendar days a payment remains delinquent, an additional 2.5% penalty shall accrue against the outstanding balance, including prior penalties. The Commission shall credit partial payments first to the current outstanding liability, and second to the amount of the penalties.

(2) Offset Collection. If a Qualifying Hospital or Qualifying Surcharge Payor is more than 45 calendar days late with a payment due pursuant to the schedule set forth in 958 CMR 2.03(3)(b) or 958 CMR 2.04(3)(b), the Commission may notify the Executive Office and the Office of Medicaid that such payments are past due. The Executive Office may reassign to the Commission any payments to the Qualifying Hospital or Qualifying Surcharge Payor in the amount of the unpaid assessment, including any interest and penalties.

The Commission shall notify any Qualifying Hospital or Qualifying Surcharge Payor at least 15 calendar days prior to notifying the Executive Office under 958 CMR 2.06(2).

2.07: Reporting Requirements

(1) General. Each Acute Hospital and Surcharge Payor shall file or make available information that is required or that the Commission deems reasonably necessary for implementation of 958 CMR 2.00.

(a) The Commission may revise the data specifications, the data collection scheduled, or other administrative requirements by administrative bulletin.

(b) The Commission may audit data submitted under 958 CMR 2.00 to ensure accuracy.

(2) Penalties. Any Acute Hospital or Surcharge Payer that fails to file data, statistics, schedules, or other information pursuant to 958 CMR 2.07 or which

falsifies same, shall be subject to a civil penalty of not more than $5,000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction.

2.08: Special Provisions

(1) Transfer of Ownership. All liabilities to the Commission by a Qualifying Hospital or Qualifying Surcharge Payor shall, in the case of a transfer of ownership, be assumed by the successor.

(2) Acute Hospital Rates. A Qualifying Hospital shall not seek an increase in rates to offset the surcharge assessment under 958 CMR 2.03. The Commission may require a Qualifying Hospital to submit a jurat or an attestation signed under the pains and penalties of perjury by a person with legal authority to bind the entity, who attests to compliance with this obligation.

(3) Surcharge Payor Premiums. A Qualifying Surcharge Payor shall not seek an increase in premiums to offset the surcharge assessment under 958 CMR 2.04. The Commission may require a Qualifying Surcharge Payor to submit a jurat or an attestation signed under the pains and penalties of perjury by a person with legal authority to bind the entity, who attests to compliance with this obligation.

(4) Severability. The provisions of 958 CMR 2.00 are severable. If any provision or the application of any provision to any Acute Hospital or Surcharge Payor 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 958 CMR 2.00 or the application of such provisions to Acute Hospitals or Surcharge Payors in circumstances other than those held invalid.

(5) Administrative Bulletins. The Commission may issue administrative bulletins to clarify policies and understanding of substantive provisions of 958 CMR 2.00 and specify information and documentation necessary to implement 958 CMR 2.00.

REGULATORY AUTHORITY

968 CMR 2.00: St. 2012, c. 224, § 241 and M.G.L. c. 6D.