

Proposed Amended 958 CMR 9.00

958 CMR: HEALTH POLICY COMMISSION

958 CMR 9.00: ASSESSMENT ON CERTAIN HEALTH CARE PROVIDERS AND PHARMACY BENEFIT MANAGERS

Section

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9.01: General Provisions

- (1) Scope and Purpose. 958 CMR 9.00 governs payments to the Health Policy Commission from Acute Hospitals, Ambulatory Surgical Centers, and Pharmacy Benefit Managers.
- (2) Applicability. 958 CMR 9.00 applies to Hospitals, Ambulatory Surgical Centers, and Pharmacy Benefit Managers, as defined by this regulation.
- (3) Authority. 958 CMR 9.00 is adopted pursuant to M.G.L. c. 6D.

9.02 Definitions

All defined terms in 958 CMR 9.00 are capitalized. As used in 958 CMR 9.00, these terms have the following meaning:

Acute Hospital. The teaching hospital of the University of Massachusetts Medical School and any 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.

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.

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

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

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Commission Expenses. The amount appropriated by the general court for the expenses of the Commission minus amounts collected from (1) filing fees; (2) fees and charges generated by the Commission; and (3) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Commission Expenses shall include an amount equal to the cost of fringe benefits and indirect expenses, as established by the comptroller.

Division. Division of Insurance established under M.G.L. c. 26.

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.

Gross Patient Service Revenue (GPSR). The total dollar amount of an Acute Hospital's or an Ambulatory Surgical Center's charges for services rendered in a Fiscal Year.

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.

Pharmacy Benefit Manager. A person, business, or other entity, however organized, subject to licensure by the Division pursuant to M.G.L. c. 176Y, that directly or through a subsidiary provides pharmacy benefit services for prescription drugs and devices on behalf of a health plan sponsor, including but not limited to, a self-insurance plan, labor union or other third party payer; provided however, that "pharmacy benefit manager" shall not include a health benefit sponsor unless otherwise specified by the Division.

Pharmacy Benefit Services. Services performed by a Pharmacy Benefit Manager, including: (1) negotiating the price of prescription drugs including negotiating and contracting for direct or indirect rebates, discounts or other price concessions; (ii) managing any aspects of a prescription drug benefit, including, but not limited to, formulary administration, mail-order pharmacy and specialty drug pharmacy services, clinical, safety and adherence programs for pharmacy service, the processing and payment of claims for prescription drugs, arranging alternative access to or funding for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered prescription drugs and managing or providing data relating to the prescription drug benefit or the provision of services related thereto; (iii) performance of any administrative, managerial, clinical, pricing, financial, reimbursement, data administration or reporting or billing service related to a health benefit plan's prescription drug benefit; and (iv) such other services as the Division may define in regulation.

9.03 Acute Hospital and Ambulatory Surgical Center Assessment

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(1) General. The Commission shall establish an assessment on all Acute Hospitals and Ambulatory Surgical Centers; provided, however, that the Commission shall not assess any Acute Hospital operated by a city or town.

(2) Calculation of the Acute Hospital and Ambulatory Surgical Center Assessment Percentage. Using the best information available as determined by the Commission, the Commission shall calculate an Assessment Percentage for each Acute Hospital and Ambulatory Surgical Center by dividing each entity's individual GPSR for the most recent Fiscal Year for which complete data was reported to the Center pursuant to 957 CMR 3.00 by the total of all such GPSR reported by all Acute Hospitals and Ambulatory Surgical Centers.

(3) Acute Hospital and Ambulatory Surgical Center Assessment Liability. The assessment liability for each Acute Hospital and Ambulatory Surgical Center is the product of (a) the Assessment Percentage as defined in 958 CMR 9.03(2) and (b) forty percent of Commission Expenses.

(4) Payment Process.

(a) Unless otherwise specified by the Commission, each Acute Hospital and Ambulatory Surgical Center shall make a preliminary payment to the Commission on October 1 of each year, in an amount equal to one-half of the Acute Hospital or Ambulatory Surgical Center's previous year's total assessment.

(b) Each Acute Hospital and Ambulatory Surgical Center shall pay the balance of its total assessment within 30 days' notice from the Commission.

(c) The Commission shall, using the best information available as determined by the Commission, adjust the assessment to account for any variation in actual Commission Expenses and any changes in Acute Hospital and/or Ambulatory Surgical Center gross patient service revenues.

(d) All assessment payments must be payable to the Commonwealth of Massachusetts in United States dollars and drawn on a United States bank.

9.04 Pharmaceutical Benefit Manager Assessment

(1) General. The Commission shall establish an assessment on all Pharmaceutical Benefit Managers licensed pursuant to M.G.L. chapter 176Y.

(2) Claims Subject to Assessment. Claims paid for Massachusetts residents for the most recent calendar year, as reported to the Division pursuant to said chapter 176Y or the Center pursuant to M.G.L. c. 12C or any regulations promulgated thereunder, are subject to assessment.

(3) Calculation of the Pharmaceutical Benefit Manager Assessment Percentage. Using the best information available as determined by the Commission, the Commission shall calculate each Pharmaceutical Benefit Manager Assessment Percentage by dividing an individual Pharmaceutical Benefit Manager's Claims Subject to Assessment during the

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last Fiscal Year for which complete data was received by the Division or the Center by the total of all such claims paid by all Pharmaceutical Benefit Managers reported to the Division or the Center.

(4) Pharmaceutical Benefit Manager Liability. The assessment liability for each Pharmaceutical Benefit Manager is the product of (a) the Pharmaceutical Benefit Manager Assessment Percentage, as defined in 958 CMR 9.04 (3), and (b) ten percent of Commission Expenses.

(5) Payment Process.

(a) Unless otherwise specified by the Commission, each Pharmaceutical Benefit Manager shall make a preliminary payment to the Commission on October 1 of each year in an amount equal to one-half of the Pharmaceutical Benefit Manager's previous year's total assessment.

(b) Each Pharmaceutical Benefit Manager shall pay, within 30 days' notice from the Commission, the balance of its total assessment.

(c) The Commission shall, using the best information available as determined by the Commission, adjust the assessment to account for any variation in actual Commission Expenses.

(d) All assessment payments must be payable to the Commonwealth of Massachusetts in United States dollars and drawn on a United States bank

9.05 Special Provisions

(1) Transfer of Ownership. All liabilities to the Commission by an Acute Hospital, Ambulatory Surgical Center or Pharmacy Benefit Manager shall, in the case of a transfer of ownership, be assumed by the successor.

(2) Severability. The provisions of 958 CMR 9.00 are severable. If any provision or the application of any provision to any Acute Hospital, Ambulatory Surgical Center, or Pharmacy Benefit Manager is held to be invalid or unconstitutional, any such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 958 CMR 9.00 or the application of such provisions to any Acute Hospital, Ambulatory Surgical Center, or Pharmacy Benefit Manager in circumstances other than those held invalid.

(3) Administrative Bulletins. The Commission may issue administrative bulletins to clarify policies and understanding of substantive provisions of 958 CMR 9.00 and specify information and documentation necessary to implement 958 CMR 9.00.

(4) Debt Collection. If an Acute Hospital, Ambulatory Surgical Center or Pharmacy Benefit Manager has maintained an outstanding liability to the Commission for a period longer than 120 days, the Commission will pursue all legal remedies available to it, including those available under M.G.L. c. 7A, §3.

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REGULATORY AUTHORITY

958 CMR 9.00: M.G.L. c. 6D