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SENATE . . . . . No. 587

The Commonwealth of Massachusetts

In the Year Two Thousand Nine

An Act relative to parity in assessments by the health care safety net fund..

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. Section 34 of Chapter 118G of the General Laws is hereby amended by striking it in its entirety and replacing it with the following:-

“Section 34. Definitions applicable to Secs. 34 to 39”

"Acute hospital", the teaching hospital of the University of Massachusetts medical school and any hospital licensed under section 51 of chapter 111 and which contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public health.

"Allowable reimbursement", payment to acute hospitals and community health centers for health services provided to uninsured or underinsured patients of the commonwealth under section 39 and any further regulations promulgated by the health safety net office.

"Ambulatory surgical center", a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and meets the

requirements of the federal Health Care Financing Administration for participation in the Medicare program.

“Ambulatory surgical center services”, notwithstanding any provision of general or special law or regulation to the contrary, shall be defined as services described for purposes of the Medicare program under 42 U.S.C. 1395k(a)(2)(F)(I). These services include both facility services and surgical and other related medical procedures.

"Bad debt", an account receivable based on services furnished to a patient which: (i) is regarded as uncollectible, following reasonable collection efforts consistent with regulations of the office, which regulations shall allow third party payers to negotiate with hospitals to collect the bad debts of its enrollees; (ii) is charged as a credit loss; (iii) is not the obligation of a governmental unit or the federal government or any agency thereof; and (iv) is not a reimbursable health care service.

"Community health center", a health center operating in conformance with the requirements of Section 330 of United States Public Law 95-626, including all community health centers which file cost reports as requested by the division of health care finance and policy.

"Critical access services", those health services which are generally provided only by acute hospitals, as further defined in regulations promulgated by the division.

"Director", the director of the health safety net office.

"DRG", a patient classification scheme known as diagnosis related grouping, which provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost incurred by the hospital.

"Emergency bad debt", bad debt resulting from emergency services provided by an acute hospital to an uninsured or underinsured patient or other individual who has an emergency medical condition that is regarded as uncollectible, following reasonable collection efforts consistent with regulations of the office.

"Emergency medical condition", a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. 1295dd(e)(1)(B).

"Emergency services", medically necessary health care services provided to an individual with an emergency medical condition.

"Financial requirements", a hospital's requirement for revenue which shall include, but not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of depreciation of plant and equipment and the reasonable costs associated with changes in medical practice and technology.

"Fund", the Health Safety Net Trust Fund established under section 36.

"Fund fiscal year", the 12-month period starting in October and ending in September.

"Gross patient service revenue", the total dollar amount of a hospital's charges for services rendered in a fiscal year.

"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 associated with the provision of blood and its derivatives shall be payable.

"Laboratory," shall be defined for these purposes as a laboratory that is licensed by the department of public health and pursuant to M.G.L. c. 111D section 1(1) that is not operated by a community health center.

"Office", the health safety net office established under section 35.

"Payments subject to surcharge", notwithstanding any provision of general or special law or regulation to the contrary, shall be defined as all amounts paid, directly or indirectly, by surcharge payors to acute hospitals for health care services, to ambulatory surgical centers for ambulatory surgical center services, to specialty health care providers for specialty health care services, and to laboratories as defined in this section; and provided, however, that "payments subject to surcharge" shall not include: (i) payments, settlements and property or casualty insurance policies; (ii) payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in policies issued under chapter 176K or similar policies issued on a group basis; and provided further, that "payments subject to surcharge" may exclude amounts established by regulations promulgated by the division for which the costs and efficiency of

billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost effective.

"Pediatric hospital", an acute care hospital which limits services primarily to children and which qualifies as exempt from the Medicare Prospective Payment system regulations.

"Pediatric specialty unit", a pediatric unit of an acute care hospital in which the ratio of licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20. In calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds, and the total of all licensed hospital beds shall include the total of all licensed acute care hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

"Private sector charges", gross patient service revenue attributable to all patients less gross patient service revenue attributable to Titles XVIII and XIX, other public-aided patients, reimbursable health services and bad debt.

"Reimbursable health services", health services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or part, under applicable regulations of the office; provided that the health services are emergency, urgent and critical access services provided by acute hospitals or services provided by community health centers; and provided further, that such services shall not be eligible for reimbursement by any other public or private third-party payer.

"Resident", a person living in the commonwealth, as defined by the office by regulation; provided, however, that such regulation shall not define as a resident a person who moved into the commonwealth for the sole purpose of securing health insurance under this chapter.

Confinement of a person in a nursing home, hospital or other medical institution shall not in and of itself, suffice to qualify such person as a resident.

"Specialty health care provider", shall be defined as any entity including a physician practice providing outpatient services typically provided in a hospital setting, including but not limited to: (1) an entity providing anesthesia, conscious sedation and/or diagnostic injection services (including endoscopy services and excluding dental facilities); (ii) an entity employing major medical, diagnostic and/or therapeutic equipment, including but not limited to equipment defined as new technology or as providing an innovative service, pursuant to chapter 111, section 25B and excluding x-ray equipment; and (iii) which is not a hospital, ambulatory surgical center or community health center. The department shall promulgate regulations with respect to the classification of specialty health care providers.

"Surcharge payor", notwithstanding any provision of general or special law or regulation to the contrary, shall be defined as an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals, ambulatory surgical center services provided by ambulatory surgical centers, specialty health care services provided by specialty health care providers, and laboratory services provided by laboratories, as defined in this section; provided, however, that 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 by chapter 152.

"Underinsured patient", a patient whose health insurance plan or self-insurance health plan does not pay, in whole or in part, for health services that are eligible for reimbursement

from the health safety net trust fund, provided that such patient meets income eligibility standards set by the office.

"Uninsured patient", a patient who is a resident of the commonwealth, who is not covered by a health insurance plan or a self-insurance health plan and who is not eligible for a medical assistance program.

SECTION 2. Section 35 of Chapter 118G of the General Laws is hereby amended by inserting after the phrase “acute hospitals” the following:- “, ambulatory surgical centers, specialty health care providers, laboratories,”.

SECTION 3. Section 36 of Chapter 118G of the General Laws is hereby amended by inserting after the phrase “all amounts paid by acute hospitals” the following:- “, ambulatory surgical centers, specialty health care providers, laboratories,”.

SECTION 4. Section 37 of Chapter 118G of the General Laws is hereby amended by adding the following subsection prior to subsection (a):-

“(a) Ambulatory surgical centers, specialty health care providers, and laboratories, notwithstanding any provision of general or special law or regulation to the contrary, shall be liable to the health care safety net trust fund in the same manner as acute care hospitals. The division of health care finance and policy, in consultation with the office of Medicaid, shall establish through implementing regulations the mechanism by which the liability of said providers is to be assessed, paid, monitored, and enforced.”

SECTION 5. The General Laws are hereby amended, after each appearance of the term "acute hospital", by inserting the following phrase:- "and ambulatory surgical center, specialty health care provider, and laboratory".

SECTION 6. The General Laws are hereby amended, after each appearance of the term "ambulatory surgical center", by inserting the following phrase:- ", specialty health care provider, and laboratory".