

HOUSE No. 4070

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

An Act relative to Health Care Quality Improvement and Cost Reduction Act of 2012.

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

1 SECTION 1. Sections 16J to 16L, inclusive, of chapter 6A of the General Laws, as
2 appearing in the 2010 Official Edition, are hereby repealed.

3 SECTION 2. The chapter 10 of the General Laws, as so appearing, is hereby amended
4 by adding after section 74 the following section:—

5 Section 75. There shall be established and set up on the books of the commonwealth a
6 Wellness and Prevention Trust Fund to promote wellness at the community level in partnership
7 with clinical providers within a certain geographic area. The fund shall consist of revenues
8 collected by the commonwealth: (1) any fines and penalties allocated to the fund under the
9 General Laws; and (2) from public and private sources as gifts, grants and donations.

10 All revenues credited under this section shall remain in the Wellness and Prevention
11 Trust Fund, not subject to appropriation, to be expended by the department of public health on
12 wellness and prevention activities linked to clinical care and population-based public health

13 needs. The state treasurer shall not deposit or otherwise transfer the revenues to the General Fund
14 or any other fund.

15 The state treasurer shall deposit the moneys in the fund in accordance with section 34 of
16 chapter 29 in a manner that will secure the highest interest available consistent with the safety of
17 the fund and with the requirement that all amounts on deposit shall be available for immediate
18 withdrawal at all times. The fund shall be expended at the direction of the commissioner of
19 public health only for the purposes stated in this section and any unexpended balances in the
20 fund at the end of the fiscal year shall not revert to the general fund and shall be available for
21 expenditures in the subsequent fiscal year.

22 SECTION 3. Chapter 12 of the General Laws, as so appearing, is hereby amended by
23 inserting after section 11L the following section:—

24 Section 11M. As used in this section, terms shall have the meanings assigned by section
25 1 of chapter 118G.

26 The attorney general shall:

27 (a) monitor trends in the health care market during the reorganization of the health care
28 system including, but not limited to trends in accountable care organization size and
29 composition, consolidation in the ACO and provider markets, payer contracting trends, impact
30 on patient selection of provider and ACO, and other market effects of the transition from fee-for-
31 service forms of payment.

32 (b) in consultation with the division of health care cost and quality, take appropriate
33 action to prevent excess consolidation or collusion of providers, ACOs, or payers and to remedy
34 these or other related anti-competitive dynamics in the health care market;

35 (c) provide assistance as needed to support efforts by the commonwealth to obtain
36 waivers from certain provisions of federal law including, from the federal office of the inspector
37 general, a waiver of the provisions of, or expansion of the “safe harbors” provided for under 42
38 U.S.C. section 1320a-7b; and a waiver of the provisions of 42 U.S.C. section 1395nn(a) to (e).

39 SECTION 4. Section 7A of chapter 26, as so appearing, is hereby amended by inserting
40 at the end, the following paragraph:—

41 The division shall create a model wellness guide for payers, employers and consumers.
42 The guide shall provide the following information: 1) the importance of healthy lifestyles,
43 disease prevention, the benefits of care management, and health promotion; 2) financial and
44 other incentives for participating in wellness programs; 3) explanation of the use of technology
45 to provide wellness information and services; 4) the benefits of participating in tobacco cessation
46 programs, weight loss programs, and compliance with disease management; 5) a description of
47 the discounts available to employees under the Affordable Care Act; and 6) the ability for payers
48 to reduce premiums by offering incentives to patients with chronic diseases or high-risk of
49 hospitalization to better comply with prescribed drugs and follow up care.

50 In developing the model guide, the division shall consult with department of public
51 health and health care stakeholders, including but not limited to employers, including
52 representatives of employers 50 employees or more and representatives of employers with less

53 than 50 employees; providers, both for profit and not for profit; health plans and public payers;
54 researchers; consumers; and government.

55 SECTION 5. Chapter 29 of the General Laws, as so appearing, is hereby amended by
56 inserting after section 2BBBB the following 2 sections:—

57 Section 2CCCC. (a)There is hereby established and set up on the books of the
58 commonwealth a separate fund to be known as the Health Care Workforce Trust Fund,
59 hereinafter called the fund. The fund shall be administered by the health care workforce center
60 which may contract with any appropriate entity to administer the fund or any portion therein. The
61 purposes of the fund shall include: (i) making awards to health professionals for repayment
62 assistance for medical or nursing school loans pursuant to section 62 of chapter 118G , provided
63 that in administering the loan forgiveness grant program, a portion of funds therein shall be
64 granted to applicants performing terms of service in rural primary care sites that meet the criteria
65 of a medically underserved area as determined by the health care workforce center; (ii providing
66 employment training opportunities, job placement, career ladder and educational services for
67 currently employed or unemployed health workers who are seeking new positions or
68 responsibilities within the health care industry with a focus on aligning training and education
69 with industry needs, provided that the fund shall support the distribution of grants to selected
70 health systems, non-profit organizations, labor unions, labor-industry partnerships and others;
71 (iii) funding residency positions in primary care pursuant to section 64 of chapter 118G; and (iv)
72 funding rural health rotation programs, rural health clerkships, and rural health preceptorships at
73 medical and nursing schools to expose students to practicing in rural and small town
74 communities.

75 (b) There shall be credited to the fund all monies payable pursuant to (i) funds that are
76 paid to the health care workforce loan repayment program, established under section 62 of
77 chapter 118G, as a result of a breach of contract and private funds contributed from other
78 sources; and (ii) any revenue from appropriations or other monies authorized by the general court
79 and specifically designated to be credited to the fund, and any gifts, grants, private contributions,
80 investment income earned on the fund's assets and all other sources. Money remaining in the
81 fund at the end of a fiscal year shall not revert to the General Fund.

82 (c) The fund shall supplement and not replace existing publically-financed health care
83 workforce development programs.

84 (d) The division of health care cost and quality shall promulgate regulations pursuant to
85 the distribution of monies from the fund to programs listed under subsection (a) and applicant
86 eligibility criteria for said funds.

87 (e) The health care workforce center shall annually, not later than December 31, report to
88 the secretary of administration and finance, the house and senate committees on ways and means,
89 and the joint committee on health care financing regarding the revenues and distribution of
90 monies from the fund in the prior fiscal year.

91 Section 2DDDD. There is hereby established and set up on the books of the
92 commonwealth a separate fund to be known as the Distressed Hospital Trust Fund, which shall
93 be administered by the division of health care cost and quality. Expenditures from the Distressed
94 Hospital Trust Fund shall be dedicated to efforts to improve and enhance the ability of
95 community hospitals to serve populations in need more efficiently and effectively, including, but
96 not limited to, the ability to provide community-based care, clinical support and care

97 coordination services, improve health information technology, or other efforts to create effective
98 coordination of care.

99 The division, in consultation with the Massachusetts Hospital Association, shall develop
100 a competitive grant process for awards to be distributed to distressed hospitals out of said fund.
101 The grant process shall consider the following factors, including but not be limited to (1) payer
102 mix, (2) financial health, (3) geographic need, and (4) population need.

103 SECTION 6. Chapter 32A of the General Laws, as so appearing, is hereby amended by
104 inserting after section 26 the following 3 sections:-

105 Section 27. Pursuant to section 50 of chapter 118G, the commission shall provide a toll-
106 free number and website that enables consumers to request and obtain from the commission in
107 real time the maximum estimated amount the insured will be responsible to pay for a proposed
108 admission, procedure or service that is a medically necessary covered benefit, based on the
109 information available to the carrier at the time the request is made, including any copayment,
110 deductible, coinsurance or other out of pocket amount and the actual or maximum estimated
111 allowed amount, for any health care benefits.

112 As used in this section, “allowed amount” shall mean the contractually agreed upon
113 amount paid by a carrier to a health care provider for health care services provided to an insured.

114 Section 28. The commission shall attribute every member to a primary care provider.

115 Section 29. Pursuant to section 50 of chapter 118G, the commission shall disclose
116 patient-level data including, but not limited to, health care service utilization, medical expenses,
117 demographics, and where services are being provided, to all providers in their network, provided

118 that data shall be limited to patients treated by that provider, in order to aid providers in
119 managing the care of their own patient panel.

120 SECTION 7. Chapter 32B of the General Laws, as so appearing, is hereby amended by
121 inserting after section 20 the following 3 sections:-

122 Section 21. Pursuant to section 50 of 118G, every appropriate public authority which has
123 accepted this chapter shall provide a toll-free number and website that enables consumers to
124 request and obtain from the public authority in real time the maximum estimated amount the
125 insured will be responsible to pay for a proposed admission, procedure or service that is a
126 medically necessary covered benefit, based on the information available to the carrier at the time
127 the request is made, including any copayment, deductible, coinsurance or other out of pocket
128 amount for any health care benefits.

129 Section 22. Every appropriate public authority which has accepted this chapter shall
130 attribute every member to a primary care provider.

131 Section 23. Pursuant to section 50 of chapter 118G, every appropriate public authority
132 which has accepted this chapter shall disclose patient-level data including, but not limited to,
133 health care service utilization, medical expenses, demographics, and where services are being
134 provided, to all providers in their network, provided that data shall be limited to patients treated
135 by that provider, so as to aid providers in managing the care of their own patient panel.

136 SECTION 8. Sections 6D, 6E, 6F and 6G of chapter 40J of the General Laws, as so
137 appearing, are hereby repealed.

138 SECTION 9. Section 6 of chapter 62 of the General Laws, as so appearing, is hereby
139 amended by inserting after subsection (q) the following subsection:—

140 (r) (1) An employer subject to tax under this chapter which participates in a wellness
141 program may take a credit against the excise imposed under this chapter in an amount equal to
142 25 percent of the costs associated with implementing the plan, with a maximum credit of
143 \$10,000.

144 (2) The credit shall be allowed if the taxpayer provides the appropriate documentation.
145 The department of revenue, in consultation with the division of insurance, shall promulgate
146 regulations to determine the necessary filings from the taxpayer. These filings shall include proof
147 of using a wellness program qualified under section 206A of chapter 111.

148 SECTION 10. Chapter 63 of the General Laws, as so appearing, is hereby amended by
149 inserting after section 38BB the following section:—

150 Section 38CC. (a) A corporation subject to tax under this chapter which participates in a
151 wellness program may take a credit against the excise imposed under this chapter in an amount
152 equal to 25% of the costs associated with the implementing the plan, with a maximum of
153 \$10,000.

154 (b) The credit shall be allowed if the taxpayer provides the appropriate documentation.
155 The department of revenue, in consultation with the division of insurance, shall promulgate
156 regulations to determine the necessary filings from the taxpayer. These filings shall include proof
157 of using a wellness program qualified under section 206A of chapter 111.

158 SECTION 11. Section 1 of chapter 111, as so appearing, is hereby amended by inserting
159 before the definition of “Board of health”, the following definition:-

160 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health
161 care provider for health care services.

162 SECTION 12. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby
163 amended by striking out, in line 38, the words “one hundred and seventy-six G” and inserting in
164 place thereof the following words:- 176G or within an accountable care organization licensed by
165 the division of health care cost and quality under chapter 118J.

166 SECTION 13. Sections 25L through 25N, inclusive, of chapter 111, as so appearing, are
167 hereby repealed.

168 SECTION 14. Section 25P is Chapter 111, as so appearing, is hereby repealed.

169 SECTION 15. Section 51H of chapter 111, as so appearing, is hereby amended by
170 striking subsection (c) and inserting in place thereof the following subsection:—

171 (c) The department, through interagency service agreements, shall transmit data collected
172 under this section to the Betsy Lehman center for patient safety and medical error reduction and
173 the division of health care cost and quality established under chapter 118G for publication on its
174 consumer health information website. Any facility failing to comply with this section may: (i) be
175 fined up to \$1,000 per day per violation; (ii) have its license revoked or suspended by the
176 department; or (iii) be fined up to \$1,000 per day per violation and have its license revoked or
177 suspended by the department.

178 SECTION 16. Chapter 111 is hereby amended by inserting after section 51H the
179 following new section:-

180 Section 51I. Separate negotiations for health care providers

181 (a) As used in this section, the following words shall have the following meanings: --

182 “Facility”, any hospital, as defined in section 52 of chapter 111 of the General Laws, or
183 clinic conducted by a hospital, as licensed under section 51 of chapter 111, which receives a
184 separate on-site review survey by the Joint Commission on the Accreditation of Healthcare
185 Organization.

186 (b) Public and private payers shall negotiate separate contracts for each facility,
187 regardless of affiliation with a system or ownership by a system.

188 (c) Each facility within a larger system shall establish separate negotiating teams.

189 (d) Every facility must establish a firewall mechanism that prevents the separate contract
190 negotiating teams from sharing any information that would inhibit them from competing with
191 each other and with other hospitals and physician practice groups.

192 (e) Contracts may not be contingent on entering into a contract with another health care
193 provider within a system.

194 (f) Contracts may not make the availability of any price or term for a contract contingent
195 on entering into a contract with another health care facility.

196 (g) Separate negotiations shall apply for both inpatient and outpatient services.

197 (h) The Department and the Office of the Attorney General shall have the authority to
198 enforce the requirements of this section.

199 (i) If a system has entered into alternative payment methodology contracts with a carrier
200 and more than 50 per cent of their patients are covered under alternative payment methodology
201 contracts, then they shall be exempt from the requirements of this section.

202 (j) Health care facilities shall negotiate under the requirements of this section at the time
203 of renewal or expiration of their current contracts with payers.

204 SECTION 17. Said chapter 111 is hereby amended by inserting after section 53G the
205 following section:—

206 Section 53H. (a) There shall be a division of certification of physician organizations
207 located within the department.

208 (b) The division shall have the following powers and duties:

209 (1) to develop and administer a program for certification of physician organizations
210 including, but not limited to establishing levels of certification, designing standards for practice
211 to increase the transparency, and improving the functioning of the health care system;

212 (2) to make, adopt, amend, repeal, and enforce such rules and regulations consistent with
213 law as it deems necessary for the protection of the public health, safety, and welfare and for the
214 proper administration and enforcement of its responsibilities;

215 (3) to collect reasonable fees established pursuant to section 3B of chapter 7 to support
216 the division's operations and administration;

217 (4) to establish and implement procedures for the review, investigation, resolution, or
218 referral to the appropriate provider licensing entity of such complaints involving certified
219 physician organizations, including appropriate disciplinary actions available to the division in
220 connection with complaint resolution, which may include a fine, or suspension, revocation, or
221 denial of a certificate, or a combination of the foregoing, and to discipline certificate holders in
222 accordance with procedures established by the division that shall conform with chapter 30A and
223 801 CMR 1.01 et seq.;

224 (5) to establish, in consultation with the boards of professional licensure, a standardized
225 electronic system for the public reporting of provider license information; and

226 (6) to perform such other functions and duties as may be required to carry out this
227 section.

228 (c) A physician organization shall be defined as a group of physicians contracting as a
229 single entity rather than in their individual capacities unless the group consists of 9 physicians or
230 fewer. Provided however that any licensed entity including, but not limited to hospitals and
231 clinics that directly employ physicians shall not be required to register as a physician
232 organizations.

233 (d) No later than 30 days after an application has been filed, the division may require the
234 physician organization to provide additional information to complete or supplement the filing.

235 (e) Within 45 days of receipt of a complete application, the division shall complete its
236 review of the application and send written notice to the physician or physician organization, with
237 a copy to the division of insurance, explaining its decision to: (1) issue the certification as
238 applied for; (2) issue the certification as applied for but with conditions that restrict certain

239 material changes without prior approval; (3) issue a certification at a lower certification level
240 than applied for; (4) reject the application for failure to comply with the requirements of the
241 application process, with instructions that the application may be resubmitted within 10 days; or
242 (5) deny the application.

243 (f) Any physician organization whose application has been rejected or denied, or who has
244 been issued a certificate with conditions or at a lower level than applied for, may request an
245 adjudicatory hearing pursuant to chapter 30A within 21 days of the division's decision. The
246 division shall notify the attorney general and the division of insurance upon receipt of such
247 hearing request. Said hearing shall be conducted within 30 days of the division's receipt of the
248 hearing request. The attorney general may intervene in a hearing under this subsection and may
249 require the production of additional information or testimony. The commissioner shall issue a
250 written decision within 30 days of the conclusion of the hearing.

251 (g) A physician organization aggrieved by said written decision may, within 20 days of
252 said decision, file a petition for review in the Suffolk superior court. Review by the supreme
253 judicial court on the merits shall be limited to the record of the proceedings before the
254 commissioner and shall be based upon the standards set forth in paragraph (7) of section 14 of
255 chapter 30A.

256 SECTION 18. Chapter 111 of the General Laws is hereby amended by inserting after
257 section 206 the following section:-

258 Section 206A. The commissioner shall provide a wellness seal of approval to a wellness
259 program that is actuarially equivalent to the programs defined in section 206 of this chapter. The

260 commissioner, in consultation with the commissioner of the department of revenue, shall create
261 the appropriate form for showing that an employer is using an approved wellness program.

262 SECTION 19. Section 217 of said chapter 111, as so appearing, is hereby repealed

263 SECTION 20. Said chapter 111, as so appearing, is hereby amended by inserting after
264 section 224 the following 2 sections:—

265 Section 225. (a) Upon request by a patient or prospective patient, a health care provider
266 shall disclose the charges, and if available, the allowed amount, or where it is not possible to
267 quote a specific amount in advance due to the health care provider’s inability to predict the
268 specific treatment or diagnostic code, the estimated charges or estimated allowed amount for a
269 proposed admission, procedure or service.

270 (b) A health care provider referring a patient to another provider that is part of or
271 represented by the same provider organization as defined in section 53H shall disclose (i) that the
272 providers are part of or represented by the same provider organization, and upon the request by
273 the patient, (ii) the charges, and if available, the allowed amount, or where it is not possible to
274 quote a specific amount in advance due to the health care provider’s inability to predict the
275 specific treatment or diagnostic code, the estimated charges or estimated allowed amount for a
276 proposed admission, procedure or service.

277 As used in this section, “allowed amount”, shall mean the contractually agreed upon
278 amount paid by a carrier to a health care provider for health care services provided to an insured.

279 Section 226. (a) As used in this section, the following words shall, unless the context
280 requires otherwise, have the following meanings:—

281 “Hospital”, a hospital licensed under section 51 of chapter 111, the teaching hospital of
282 the University of Massachusetts medical school, a licensed private or state-owned and state-
283 operated general acute care hospital, or an acute care unit within a state-operated facility;
284 provided, however, that “hospital” shall not include a licensed non-acute care hospital classified
285 as an inpatient rehabilitation facility, an inpatient substance abuse facility, or a long term care
286 hospital by the federal Centers for Medicare and Medicaid Services.

287 “Nurse”, a registered nurse licensed under section 74 of chapter 112 or a licensed
288 practical nurse licensed under section 74A of said chapter 112.

289 “Mandatory Overtime”, any hours worked by a nurse in a hospital setting to deliver
290 patient care, beyond the predetermined and regularly scheduled number of hours that the hospital
291 and nurse have agreed that the employee shall work, provided that in no case shall such
292 predetermined and regularly scheduled number of hours exceed 12 hours in any 24 hour period.

293 (b) Notwithstanding any general or special law to the contrary, a hospital shall not require
294 a nurse to work mandatory overtime except in the case of an emergency situation where the
295 safety of the patient requires its use and when there is no reasonable alternative.

296 (c) Pursuant to paragraph (b), whenever there is an emergency situation where the safety
297 of a patient requires its use and when there is no reasonable alternative, the facility shall, before
298 requiring mandatory overtime, make a good faith effort to have overtime covered on a voluntary
299 basis. Mandatory overtime shall not be used as a practice for providing appropriate staffing for
300 the level of patient care required.

301 (d) The department of public health in consultation with the Massachusetts Nurses
302 Association and the Massachusetts Hospital Association, and other organizations, shall

303 determine what constitutes an “emergency situation.” The department shall solicit feedback
304 through public hearing. The department of public health on or before February 1, 2013 shall
305 promulgate regulations or guidelines to implement the findings of this section.

306 (e) Beginning April 15, 2013, hospitals shall report all instances of mandatory overtime,
307 and the circumstances requiring its use, to the department of public health. Such reports shall be
308 public documents.

309 (f) The department of public health on or before January 1, 2014 shall promulgate
310 regulations to establish a system to levy an administrative fine on any facility that violates this
311 act or any regulation issued under this act. The fine shall be not less than \$100 and not greater
312 than \$1,000 for each violation and fines collected shall be dedicated to the department of public
313 health’s statewide sexual assault nurse examiner program. Said regulations shall also establish an
314 independent appeals process for penalized entities.

315 (g) A nurse shall not be allowed to exceed sixteen consecutive hours worked in a twenty-
316 four hour period. In the event a nurse works sixteen consecutive hours, said nurse must be given
317 at least eight consecutive hours of off-duty time immediately after the worked overtime.

318 (h) The provisions of this section are intended as a remedial measure to protect the public
319 health and the quality and safety of patient care, and shall not be construed to diminish or waive
320 any rights of the nurse pursuant to any other law, regulation, or collective bargaining agreement.
321 The refusal of an nurse to accept work in excess of the limitations set forth in this section shall
322 not be grounds for discrimination, dismissal, discharge or any other employment decision.

323 (i) Nothing in this section shall be construed to limit, alter or modify the terms,
324 conditions or provisions of a collective bargaining agreement entered into by a hospital and a
325 labor organization.

326 SECTION 21. Section 2 of chapter 112 of the General Laws, as so appearing, is hereby
327 amended by inserting the following after the second sentence of the first paragraph:—The board
328 shall require, as a standard of eligibility for licensure, that applicants demonstrate proficiency in
329 the use of computerized physician order entry, e-prescribing, electronic health records and other
330 forms of health information technology, as determined by the board. As used in this section,
331 proficiency, at a minimum shall mean that applicants demonstrate the skills to comply with the
332 “meaningful use” requirements, so-called, as set forth in 45 C.F.R. Part 170.

333 SECTION 22. Said chapter 112, as so appearing, is hereby amended by inserting after
334 section 2C, the following section:—

335 Section 2D. No physician shall enter into a contract or agreement, which creates or
336 establishes a partnership, employment or any other form of professional relationship that
337 prohibits a physician from providing testimony in an administrative or judicial hearing, including
338 cases of medical malpractice.

339 SECTION 23. Section 9C of chapter 112 of the General Laws, as so appearing, is hereby
340 amended by striking the definition of “physician assistant” and inserting in place thereof the
341 following definition:-

342 “Physician assistant,” a person who is duly registered and licensed by the board.

343 SECTION 24. Section 9E of chapter 112 of the General Laws, as so appearing, is hereby
344 amended by striking out, in lines 5 and 6, the words “A registered physician shall supervise no
345 more than 4 physician assistants at any one time.”.

346 SECTION 25. Said section 9E, as so appearing, is hereby amended by striking out, in
347 lines 15 through 17, the words “Any prescription of medication made by a physician assistant
348 must include the name of the supervising physician.”.

349 SECTION 26. Chapter 112 of the General Laws is hereby amended by inserting after
350 section 80H the following section:—

351 Section 80I. When a provision of law or rule requires a signature, certification, stamp,
352 verification, affidavit or endorsement by a physician, when relating to physical or mental health,
353 that requirement may be fulfilled by a nurse practitioner practicing under section 80B of chapter
354 112. Nothing in this section shall be construed to expand the scope of practice of nurse
355 practitioners. This section shall not be construed to preclude the development of mutually
356 agreed upon guidelines between the nurse practitioner and supervising physician under section
357 80E of chapter 112.

358 SECTION 27. Chapter 118E of the General Laws, as so appearing, is hereby amended by
359 adding the following 8 sections:—

360 Section 63. In connection with the governor’s fiscal year 2015 budget recommendation,
361 the secretary of administration and finance and the director of Medicaid shall submit to the
362 legislature a plan to ensure greater predictability and stability in the rates paid by Medicaid to
363 health care providers. The plan shall include the establishment of a Medicaid reserve fund or a

364 similar mechanism that will allow the office of Medicaid to establish rates paid to providers at
365 least 12 months prior to the time such rates take effect.

366 Section 64. As of July 1, 2013, rates paid by Medicaid to acute care hospitals and to
367 providers of primary care services shall increase by 2 percent, provided, however, that only those
368 hospitals and providers that have demonstrated to the satisfaction of the division of health care
369 cost and quality a significant transition to the use of alternative payment methodologies shall be
370 eligible for the increased payment rate. The division shall establish by regulation what
371 constitutes a significant use of alternative payment methodologies by a provider. The increase in
372 Medicaid rates provided for in this section shall not be included in the calculation of state wide
373 health care cost growth targets under section 46 of chapter 118G.

374 Section 65. During fiscal year 2013, the office of Medicaid shall develop an accountable
375 care organization and patient-centered medical home innovation project that employs alternative
376 payment methodologies including but not limited to bundled payments, global payments, shared
377 savings and accountability for downstream spending and other innovative methods of paying for
378 health care services. The office of Medicaid shall take actions necessary to amend its managed
379 care organization and primary care clinician contracts as necessary to include such contracts in
380 the innovation project.

381 Section 66. To the greatest extent possible, the office of Medicaid shall pay for health
382 care using the accountable care organization, or patient-centered medical home model of
383 delivering health care services. In making the transition to ACOs and patient-centered medical
384 homes, the office of Medicaid shall achieve the following benchmarks:

385 (i) By January 1, 2013, the office of Medicaid must pay for health care based on the
386 ACO or medical home health care delivery model for at least 25 percent of its enrollees.

387 (ii) By January 1, 2014, the office of Medicaid must pay for health care based on the
388 ACO or medical home health care delivery model for at least 50 percent of its enrollees.

389 (iii) By January 1, 2015, the office of Medicaid must pay for health care based on the
390 ACO or medical home health care delivery model for at least 80 percent of its enrollees.

391 Section 67. To the extent that the office of Medicaid continues to pay acute care hospitals
392 and other providers on a fee-for-service basis, the office shall establish, in cases in which the
393 office believes it would enhance the health care quality and spending control objectives of this
394 act, a shared savings payment program. Under such a program, if a provider is paid on a fee-
395 for-service basis and the provider's total reimbursements have increased at a rate lower than the
396 health care cost growth benchmarks established in section 46 of chapter 118G, such provider
397 shall receive a share of the savings and the remainder of the savings shall be retained by the
398 commonwealth. If a provider is paid on a fee-for-service basis and the provider's total
399 reimbursements have increased at a rate greater than the health care cost growth benchmarks
400 established in section 46 of chapter 118G, the commonwealth shall pay a share of the excess of
401 the rate of growth in such fees above the applicable cost growth benchmark and the remainder
402 shall be borne by the provider.

403 Section 68. MassHealth shall implement no later than July 1, 2013 the Express Lane re-
404 enrollment program for streamlined eligibility procedures to renew eligibility for parents with
405 children who are enrolled in the SNAP program.

406 Section 69. The office of medicaid and the commonwealth health insurance connector
407 authority shall, to the greatest extent possible, work to ensure that the same health care plans are
408 offered through MassHealth and Commonwealth Care so that persons transitioning between
409 different payers do not have to switch health plans. Persons deemed eligible for medical benefits
410 pursuant to section 9A of chapter 118E or section 2 of chapter 118H shall continue to be eligible
411 for assistance and remain enrolled in said programs for a period of 12 months, until the
412 member’s annual eligibility review, if the member would otherwise be determined ineligible due
413 to excess countable income but otherwise remain eligible.

414 Section 70. The division of medical assistance shall attribute every member to a primary
415 care provider.

416 SECTION 28. Section 1 of chapter 118G, as so appearing, is hereby amended by striking
417 out said section in its entirety and inserting in place thereof the following:—

418 As used in this chapter, the following words shall, unless the context clearly requires
419 otherwise, have the following meanings:—

420 “Actual costs”, all direct and indirect costs incurred by a hospital or a community health
421 center in providing medically necessary care and treatment to its patients, determined in
422 accordance with generally accepted accounting principles.

423 “Acute hospital”, the teaching hospital of the University of Massachusetts Medical
424 School and any hospital licensed under section 51 of chapter 111 and which contains a majority
425 of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the department of
426 public health.

427 “Accountable care organization” or “ACO”, means an accountable care organization
428 licensed under chapter 118J.

429 “ACO Participant”, a health care provider that either integrates or contracts with an ACO
430 to provide services to ACO patients.

431 “ACO Patient”, an individual who chooses or is attributed to an ACO for his course of
432 medical treatment, for whom such services are paid by the payer to the ACO.

433 “After-hours care”, services provided in the office during regularly scheduled evening,
434 weekend or holiday office hours, in addition to basic service.

435 “Allowed amount,” the contractually agreed upon amount paid by a payer to a health care
436 provider for health care services provided to an insured.

437 “Alternative payment contract”, an agreement between a payer and an ACO or other
438 provider in which reimbursement available under the agreement is pursuant to an alternative
439 payment methodology, as defined in this chapter, for services provided by an ACO or other
440 provider. The contract shall include at least some performance based quality measures with
441 associated financial rewards or penalties, or both.

442 “Alternative payment methodologies or methods”, methods of payment that compensate
443 ACOs and other providers for the provision of health care services, including but not limited to
444 shared savings arrangements, bundled payments for acute care episodes, bundled payments for
445 chronic diseases, and global payments, as defined in regulations adopted by the division.
446 Alternative payment methodologies shall include a risk adjustment for health status. No payment
447 based on the fee-for-service methodology shall be considered an alternative payment.

448 “Ambulatory surgical center”, any distinct entity that operates exclusively for the
449 purpose of providing surgical services to patients not requiring hospitalization and meets the
450 requirements of the federal Health Care Financing Administration for participation in the
451 Medicare program.

452 “Ambulatory surgical center services”, services described for purposes of the Medicare
453 program pursuant to 42 USC § 1395k(a)(2)(F)(I). These services include facility services only
454 and do not include surgical procedures.

455 “Bad debt”, an account receivable based on services furnished to any patient which (i) is
456 regarded as uncollectable, following reasonable collection efforts consistent with regulations of
457 the division, which regulations shall allow third party payers to negotiate with hospitals to collect
458 the bad debt of its enrollees, (ii) is charged as a credit loss, (iii) is not the obligation of any
459 governmental unit or of the federal government or any agency thereof, and (iv) is not free care.

460 “Bundled payment for acute care episode,” a single payment for the estimated cost of all
461 the services, either inpatient or outpatient, associated with clinically defined episode of care,
462 which may include, but not be limited to follow-up care or rehabilitation services.

463 “Bundled payment for chronic diseases,” a single payment for the care of a chronic
464 disease that includes all physician, clinic, inpatient and outpatient services related to that
465 condition for a specified period of time.

466 “Case mix”, the description and categorization of a hospital’s patient population
467 according to criteria approved by the division including, but not limited to, primary and
468 secondary diagnoses, primary and secondary procedures, illness severity, patient age and source
469 of payment.

470 “Charge”, the uniform price for specific services within a revenue center of a hospital.

471 “Child”, a person who is under eighteen years of age.

472 “Community health centers”, health centers operating in conformance with the
473 requirements of Section 330 of United States Public Law 95-626 and shall include all community
474 health centers which file cost reports as requested by the division.

475 “Comprehensive cancer center”, the hospital of any institution so designated by the
476 national cancer institute under the authority of 42 USC sections 408(a) and 408(b) organized
477 solely for the treatment of cancer, and offered exemption from the medicare diagnosis related
478 group payment system under 42 C.F.R. 405.475(f).

479 “Dependent”, the spouse and children of any employee if such persons would qualify for
480 dependent status under the Internal Revenue Code or for whom a support order could be granted
481 under chapters 208, 209 or 209C.

482 “Disproportionate share hospital”, any acute hospital that exhibits a payer mix where a
483 minimum of 63 per cent of the acute hospital’s gross patient service revenue is attributable to
484 Title XVIII and Title XIX of the federal Social Security Act other government payors and free
485 care.

486 “Division”, the division of health care cost and quality established by section 2.

487 “DRG”, a diagnosis related group, which is a patient classification scheme which
488 provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost
489 incurred by the hospital.

490 “Eligible person”, a person who qualifies for financial assistance from a governmental
491 unit in meeting all or part of the cost of general health supplies, care or rehabilitative services
492 and accommodations.

493 “Emergency bad debt”, bad debt related to emergency services provided by an acute
494 hospital to an uninsured individual.

495 “Emergency medical condition”, a medical condition, whether physical or mental,
496 manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of
497 prompt medical attention could reasonably be expected by a prudent layperson who possesses an
498 average knowledge of health and medicine, to result in placing the health of the person or
499 another person in serious jeopardy, serious impairment to body function, or serious dysfunction
500 of any body organ or part, or, with respect to a pregnant woman, as further defined in section
501 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

502 “Emergency services”, medically necessary health care services provided to an individual
503 with an emergency medical condition.

504 “Employee”, a person who performs services primarily in the commonwealth for
505 remuneration for a commonwealth employer. A person who is self-employed shall not be
506 deemed to be an employee.

507 “Employer”, an employer as defined in section 1 of chapter 151A.

508 “Enrollee”, a person who becomes a member of an insurance program of the division
509 either individually or as a member of a family.

510 “Executive Director”, the executive director of the division of health care cost and
511 quality.

512 “Executive office”, executive office of health and human services.

513 “Fee-for-service”, a payment mechanism in which all reimbursable health care activity is
514 described and categorized into discreet and separate units of service and each provider is
515 separately reimbursed for each discrete service rendered to a patient.

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

520 “Fiscal year”, the twelve month period during which a hospital keeps its accounts and
521 which ends in the calendar year by which it is identified.

522 “Free care”, the following medically necessary services provided to individuals
523 determined to be financially unable to pay for their care, in whole or in part, pursuant to
524 applicable regulations of the division: (1) services provided by acute hospitals; (2) services
525 provided by community health centers; and (3) patients in situations of medical hardship in
526 which major expenditures for health care have depleted or can reasonably be expected to deplete
527 the financial resources of the individual to the extent that medical services cannot be paid, as
528 determined by regulations of the division.

529 “General health supplies, care or rehabilitative services and accommodations”, all
530 supplies, care and services of medical, optometric, dental, surgical, podiatric, psychiatric,

531 therapeutic, diagnostic, rehabilitative, supportive or geriatric nature, including inpatient and
532 outpatient hospital care and services, and accommodations in hospitals, sanatoria, infirmaries,
533 convalescent and nursing homes, retirement homes, facilities established, licensed or approved
534 pursuant to the provisions of chapter 111B and providing services of a medical or health-related
535 nature, and similar institutions including those providing treatment, training, instruction and care
536 of children and adults; provided, however, that rehabilitative service shall include only
537 rehabilitative services of a medical or health-related nature which are eligible for reimbursement
538 under the provisions of Title XIX of the Social Security Act.

539 “Global payment,” a fixed-dollar payment for the care that patients may receive in a
540 specified period of time and that places providers at financial risk for both the occurrence of
541 medical conditions as well as the management of those conditions. Global payments may include
542 both primary and specialty care.

543 “Governmental mandate”, a state or federal statutory requirement, administrative rule,
544 regulation, assessment, executive order, judicial order or other governmental requirement that
545 directly or indirectly imposes an obligation and associated compliance cost upon a provider to
546 take an action or to refrain from taking an action in order to fulfill the provider’s contractual duty
547 to a procuring governmental unit.

548 “Governmental unit”, the commonwealth, any department, agency board or commission
549 of the commonwealth, and any political subdivision of the commonwealth.

550 “Gross inpatient service revenue”, the total dollar amount of a hospital’s charges for
551 inpatient services rendered in a fiscal year.

552 “Gross patient service revenue”, the total dollar amount of a hospital’s charges for
553 services rendered in a fiscal year.

554 "Gross state product," the total annual output of the Massachusetts economy as measured
555 by the U.S. Department of Commerce, Bureau of Economic Analysis, Gross Domestic Product
556 by State series.

557 “Growth rate of potential gross state product”, the long-run average growth rate of the
558 commonwealth’s economy, ignoring fluctuations due to the business cycle.

559 “Health benefit plan”, as defined in section 1 of chapter 176J.

560 “Health Care Provider”, a provider of medical or health services or any other person or
561 organization, including, but not limited to an ACO, that furnishes, bills, or is paid for health care
562 service delivery in the normal course of business.

563 “Health care services”, supplies, care and services of medical, surgical, optometric,
564 dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative,
565 supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital
566 care and services; services provided by a community health center or by a sanatorium, as
567 included in the definition of “hospital” in Title XVIII of the federal Social Security Act, and
568 treatment and care compatible with such services or by a health maintenance organization.

569 “Health insurance company”, a company as defined in section 1 of chapter 175 which
570 engages in the business of health insurance.

571 “Health insurance plan”, the medicare program or an individual or group contract or other
572 plan providing coverage of health care services and which is issued by a health insurance

573 company, a hospital service corporation, a medical service corporation or a health maintenance
574 organization.

575 “Health maintenance organization”, a company which provides or arranges for the
576 provision of health care services to enrolled members in exchange primarily for a prepaid per
577 capita or aggregate fixed sum as further defined in section 1 of chapter 176G.

578 “Health status adjusted total medical expenses”, the total cost of care for the patient
579 population associated with a provider group based on allowed claims for all categories of
580 medical expenses and all non-claims related payments to providers, adjusted by health status,
581 and expressed on a per member per month basis, as calculated under section 6 and the
582 regulations promulgated by the commissioner.

583 “Hospital”, any hospital licensed under section 51 of chapter 111, the teaching hospital of
584 the University of Massachusetts Medical School and any psychiatric facility licensed under
585 section 19 of chapter 19.

586 “Hospital agreement”, an agreement between a nonprofit hospital service corporation and
587 the hospital signatory thereto approved by the division under section 5 of chapter 176A.

588 “Hospital service corporation”, a corporation established for the purpose of operating a
589 nonprofit hospital service plan as provided in chapter 176A.

590 “Managed health care plan”, a health insurance plan which provides or arranges for,
591 supervises and coordinates health care services to enrolled participants, including plans
592 administered by health maintenance organizations and preferred provider organizations.

593 “Medicaid program”, the medical assistance program administered by the division of
594 medical assistance pursuant to chapter 118E and in accordance with Title XIX of the Federal
595 Social Security Act or any successor statute.

596 “Medical assistance program”, the medicaid program, the Veterans Administration health
597 and hospital programs and any other medical assistance program operated by a governmental
598 unit for persons categorically eligible for such program.

599 “Medically necessary services”, medically necessary inpatient and outpatient services as
600 mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall
601 not include: (1) non-medical services, such as social, educational and vocational services; (2)
602 cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and
603 consultations; (5) court testimony; (6) research or the provision of experimental or unproven
604 procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-
605 surgery hormone therapy; and (7) the provision of whole blood; and provided, however, that
606 administrative and processing costs associated with the provision of blood and its derivatives
607 shall be payable.

608 “Medical service corporation”, a corporation established for the purpose of operating a
609 nonprofit medical service plan as provided in chapter 176B.

610 “Medicare program”, the medical insurance program established by Title XVIII of the
611 Social Security Act.

612 “Non-acute hospital”, any hospital which is not an acute hospital.

613 “Non-providing employer”, an employer of a state-funded employee, as defined in this
614 section; provided, however, that the term “non- providing employer” shall not include:—

615 (i) an employer who complies with chapter 151F for such employee;

616 (ii) an employer that is signatory to or obligated under a negotiated, bona fide collective
617 bargaining agreement between such employer and bona fide employee representative which
618 agreement governs the employment conditions of such person receiving free care;

619 (iii) an employer who participates in the Insurance Partnership Program; or

620 (iv) an employer that employs not more than 10. For the purposes of this definition, an
621 employer shall not be considered to pay for or arrange for the purchase of health care services
622 provided by acute hospitals and ambulatory surgical centers by making or arranging for any
623 payments to the uncompensated care pool.

624 “Patient”, any natural person receiving health care services from a hospital.

625 “Patient-centered medical home”, a model of health care delivery designed to provide a
626 patient with a single point of coordination for all their health care, including primary, specialty,
627 post-acute and chronic care, which is (a) patient-centered; (b) comprehensive, integrated and
628 continuous; and (c) delivered by a team of health care professionals to manage a patient’s care,
629 reduce fragmentation, and improve patient outcomes.

630 “Payer”, any entity, other than an individual, that pays providers for the provision of
631 health care services. It shall include both governmental and private entities, but excludes ERISA
632 plans.

633 “Payments from non-providing employers”, all amounts paid to the Uncompensated
634 Care Trust Fund or the General Fund or any successor fund by non-providing employers.

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

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

643 “Per capita total medical expense“, the total cost of care provided in Massachusetts to
644 Massachusetts residents, expressed on a per member per year basis, as calculated under section
645 46 and the regulations promulgated by the division. This measure excludes expenses paid for
646 entirely without insurance or through a supplemental insurance policy that is not the primary
647 policy for purposes of minimum creditable coverage requirements as defined by the
648 commonwealth connector authority.

649 “Performance incentive payment” or “pay-for-performance”, an amount paid to an
650 provider by a payer for achieving certain quality measures as defined in this chapter.
651 Performance incentive payments shall comply with this chapter, regulations of the division, and
652 the contract between a provider and a payer.

653 “Performance penalty”, an amount paid by an provider to a payer or a reduction in the
654 payments made by a payer to a provider for failing to achieve certain quality measures as herein

655 defined. Performance penalty provisions and their implementation shall comply with this
656 chapter, any regulations of the division, and the contract between a provider and a payer.

657 “Potential gross state product”, the gross state product

658 “Physician”, a medical doctor licensed to practice medicine in the commonwealth.

659 “Primary Care Physician”, a physician who has a primary specialty designation of
660 internal medicine, general practice, family practice, pediatric practice or geriatric practice.

661 “Primary care provider”, a health care professional qualified to provide general medical
662 care for common health care problems, supervises, coordinates, prescribes, or otherwise provides
663 or proposes health care services, initiates referrals for specialist care, and maintains continuity of
664 care within the scope of practice.

665 “Private health care payer”, a carrier authorized to transact accident and health insurance
666 under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a
667 nonprofit medical service corporation licensed under chapter 176B, a dental service corporation
668 organized under chapter 176E, an optometric service corporation organized under chapter 176F,
669 a self-insured plan, to the extent allowable under federal law governing health care provided by
670 employers to employees, or a health maintenance organization licensed under chapter 176G.

671 “Provider” or “health care provider”, a provider of medical or health services and any
672 other person or organization, including an ACO, that furnishes, bills, or is paid for health care
673 service delivery in the normal course of business.

674 “Provider organizations”, shall mean a provider organization certified under section 53H
675 of chapter 111.

676 “Public health care payer”, the Medicaid program established in chapter 118E; any
677 carrier or other entity that contracts with the office of Medicaid or the commonwealth health
678 insurance connector to pay for or arrange the purchase of health care services on behalf of
679 individuals enrolled in health coverage programs under Titles XIX or XXI, or under the
680 commonwealth care health insurance program, including prepaid health plans subject to the
681 provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission
682 established under chapter 32A; and any city or town with a population of more than 60,000 that
683 has adopted chapter 32B.

684 “Publicly aided patient”, a person who receives hospital care and services for which a
685 governmental unit is liable, in whole or in part, under a statutory program of public assistance.

686 “Public payer-dependent non-acute hospital”, any non-acute hospital that (1) was
687 certified by the Secretary of the United States Department of Health and Human Services as
688 participating in the federal medicare program pursuant to clause (iv) of 42 USC section 1395ww
689 (d)(1)(B) on January 1, 1996; (2) is not owned by the commonwealth; and (3) exhibits a payor
690 mix in which a minimum of 15 per cent of such hospital’s gross patient service revenue, as
691 reported on the RSC-403 for hospital fiscal year 1994, was attributable to Title XIX of the
692 federal Social Security Act. Such term does not include a hospital that was reimbursed for
693 services provided to individuals entitled to medical assistance under chapter 118E for fiscal year
694 1996 pursuant to a contract between the hospital and the division of medical assistance.

695 “Purchaser”, a natural person responsible for payment for health care services rendered
696 by a hospital.

697 “Quality measures”, the standard quality measure set as defined by the division in section
698 68.

699 “Relative prices”, the contractually negotiated amounts paid to providers by each private
700 and public carrier for health care services, including non-claims related payments and expressed
701 in the aggregate relative to the payer’s network-wide average amount paid to providers, as
702 calculated under section 6 of chapter 118G and regulations promulgated by the commissioner.

703 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
704 patient for a charge.

705 “Resident”, a person living in the commonwealth, as defined by the division by
706 regulation; provided, however, that such regulation shall not define a resident as a person who
707 moved into the commonwealth for the sole purpose of securing health insurance under this
708 chapter. Confinement of a person in a nursing home, hospital or other medical institution shall
709 not in and of itself, suffice to qualify such person as a resident.

710 “Secretary”, the secretary of health and human services.

711 “Self-employed”, a person who, at common law, is not considered to be an employee and
712 whose primary source of income is derived from the pursuit of a bona fide business.

713 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
714 business, which is not a health insurance plan, and in which the business is liable for the actual
715 costs of the health care services provided by the plan and administrative costs.

716 “Self-insured group”, A self-insured or self-funded employer group health plan.

717 “Small business”, a business in which the total number of full-time employees, when
718 averaged on an annual basis, does not exceed fifty, including only of the self-employed.

719 “Social service program”, a social, mental health, mental retardation, habilitative,
720 rehabilitative, substance abuse, residential care, adult or adolescent day care, vocational,
721 employment and training, or elder service program or accommodations, purchased by a
722 governmental unit or political subdivision of the executive office of health and human services,
723 but excluding any program, service or accommodation that: (a) is reimbursable under a Medicaid
724 waiver granted under section 1115 of Title XI of the Social Security Act; or (b) is funded
725 exclusively by a federal grant.

726 “Social service program providers”, providers of social service programs in the
727 commonwealth.

728 “Sole community provider”, any acute hospital which qualifies as a sole community
729 provider under medicare regulations or under regulations promulgated by the division, which
730 regulations shall consider factors including, but not limited to, such as isolated location, weather
731 conditions, travel conditions, percentage of Medicare, Medicaid and free care provided and the
732 absence of other reasonably accessible hospitals in the area. Such hospitals shall include those
733 which are located more than twenty-five miles from other such hospitals in the commonwealth
734 and which provide services for at least sixty percent of their primary service area.

735 “Specialty hospital”, an acute hospital which qualifies for an exemption from the
736 medicare prospective payment system regulations or any acute hospital which limits its
737 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to
738 children or patients under obstetrical care.

739 “State-funded employee”, any employed person, or dependent of such person, who
740 receives, on more than 3 occasions during any hospital fiscal year, health services paid for as free
741 care; or any employed persons, or dependents of such persons, of a company that has 5 or more
742 occurrences of health services paid for as free care by all employees in aggregate during any
743 fiscal year. An occurrence shall include all healthcare related services incurred during a single
744 visit to a health care professional.

745 “State institution”, any hospital, sanatorium, infirmary, clinic and other such facility
746 owned, operated or administered by the commonwealth, which furnishes general health supplies,
747 care or rehabilitative services and accommodations.

748 “Third party administrator”, an entity that administers payments for health care services
749 on behalf of a client in exchange for an administrative fee.

750 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX
751 programs, other governmental payers, insurance companies, health maintenance organizations
752 and nonprofit hospital service corporations. Third party payer shall not include a purchaser
753 responsible for payment for health care services rendered by a hospital, either to the purchaser or
754 to the hospital.

755 “Title XIX,” Title XIX of the Social Security Act, 42 USC 1396 et seq., or any successor
756 statute enacted into federal law for the same purposes as Title XIX.

757 “Uninsured patient”, a patient who is not covered by a health insurance plan, a self-
758 insurance health plan, or a medical assistance program.

759 SECTION 29. Section 2 of chapter 118G as so appearing is hereby amended by striking
760 out said section in its entirety and inserting in place thereof the following:—

761 Section 2. (a) There shall be a body politic and corporate and a public instrumentality to
762 be known as the division of health care cost and quality, which shall be an independent public
763 entity not subject to the supervision and control of any other executive office, department,
764 commission, board, bureau, agency or political subdivision of the commonwealth except as
765 specifically provided in any general or special law. The exercise by the division of the powers
766 conferred by this chapter shall be considered to be the performance of an essential public
767 function.

768 (b) There shall be a board, with duties and powers established by this chapter, that shall
769 govern the division. The board shall consist of 9 members: the secretary of administration and
770 finance, ex officio; the secretary of health and human services, ex officio; the secretary of
771 housing and economic development, ex officio; 2 members appointed by the governor, 1 of
772 whom shall be a health care economist and 1 of whom shall be a primary care provider licensed
773 to practice in the commonwealth; 2 members appointed by the attorney general, 1 of whom shall
774 be a practicing nurse licensed to practice in the commonwealth and 1 of whom shall be shall be
775 an expert in a health care consumer advocacy and privacy protection; 2 members appointed by
776 the state auditor, 1 of whom shall be an expert in health care administration and finance and 1 of
777 whom shall be an expert in hospital administration and finance. The governor shall designate the
778 chairperson of the board. All appointments shall serve a term of 3 years, but a person appointed
779 to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall
780 be eligible for reappointment. The board shall annually elect 1 of its members to serve as vice-

781 chairperson. Each member of the board serving ex officio may appoint a designee under section
782 6A of chapter 30.

783 (c) Five members of the board shall constitute a quorum, and the affirmative vote of 5
784 members of the board shall be necessary and sufficient for any action taken by the board. No
785 vacancy in the membership of the board shall impair the right of a quorum to exercise all the
786 rights and duties of the division. Members shall serve without pay, but shall be reimbursed for
787 actual expenses necessarily incurred in the performance of their duties.

788 (d) Any action of the division may take effect immediately and need not be published or
789 posted unless otherwise provided by law. Meetings of the division shall be subject to sections 18
790 through 25, inclusive, of chapter 30A; but, said sections shall not apply to any meeting of
791 members of the division serving ex officio in the exercise of their duties as officers of the
792 commonwealth if no matters relating to the official business of the division are discussed and
793 decided at the meeting. The division shall be subject to all other provisions of said chapter 30A,
794 and records pertaining to the administration of the division shall be subject to section 42 of
795 chapter 30 and section 10 of chapter 66. All moneys of the division shall be considered to be
796 public funds for purposes of chapter 12A. Except as otherwise provided in this section, the
797 operations of the division shall be subject to chapter 268A and chapter 268B.

798 (e) The chairperson shall nominate an executive director. Such nomination shall be
799 subject to confirmation by the board. Upon confirmation, such person shall be appointed as
800 executive director. The executive director shall supervise the administrative affairs and general
801 management and operations of the division and also serve as secretary of the division, ex officio.
802 The executive director shall receive a salary commensurate with the duties of the office. The

803 executive director may appoint other officers and employees of the division necessary to the
804 functioning of the division. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter
805 150E shall not apply to the executive director or any other employees of the division. The
806 executive director shall, with the approval of the board:

807 (i) plan, direct, coordinate and execute administrative functions in conformity with the
808 policies and directives of the board;

809 (ii) employ professional and clerical staff as necessary;

810 (iii) report to the board on all operations under their control and supervision;

811 (iv) prepare an annual budget and manage the administrative expenses of the division;

812 and

813 (v) undertake any other activities necessary to implement the powers and duties set forth
814 in this chapter.

815 (f) The members of the board shall be deemed to be directors for purposes of the fourth
816 paragraph of section 3. Chapter 268A shall apply to all board members except that the division
817 may purchase from, sell to, borrow from, contract with or otherwise deal with any organization
818 in which any board member is in anyway interested or involved; provided, however, that such
819 interest or involvement shall be disclosed in advance to the board and recorded in the minutes of
820 the proceedings of the board; and provided further, that no member shall be deemed to have
821 violated section 4 of said chapter 268A because of his receipt of his usual and regular
822 compensation from his employer during the time in which the member participates in the
823 activities of the board.

824 (g) The executive director shall appoint and may remove such agents and subordinate
825 officers as the executive director may deem necessary and may establish such subdivisions
826 within the division as he deems appropriate to fulfill the following duties: (i) to collect, analyze
827 and disseminate health care data to assist in the formulation of health care policy and in the
828 provision and purchase of health care services; (ii) to work with other state agencies including,
829 but not limited to, the department of public health and the department of mental health, the
830 division of medical assistance and the division of insurance to collect and publish data
831 concerning the cost of health insurance in the commonwealth and the health status of individuals;
832 (iii) to hold annual hearings concerning health care provider and payer costs and cost trends, and
833 to provide an analysis of health care spending trends with recommendations for strategies to
834 promote an efficient health delivery system; (iv) to administer the health safety net office and
835 trust fund established under sections 35 and 36; and (v) implement the reform of the health care
836 delivery and payment system in the commonwealth.

837 The division shall adopt and amend rules and regulations, in accordance with chapter
838 30A, for the administration of its duties and powers and to effectuate the provisions and purposes
839 of this chapter. Such regulations shall be adopted, after notice and hearing, only upon
840 consultation with representatives of nonprofit hospital service corporations established under
841 chapter 176A, elected representatives of health systems agencies designated pursuant to Title XV
842 of the federal public health service act, representatives of companies authorized to sell accident
843 and health insurance under chapter 175 and the Massachusetts Hospital Association.

844 HHS)

845 SECTION 30. Section 2A of chapter 118G of the General Laws, as so appearing, is
846 hereby amended in lines 1 and 2 be striking out the first sentence and inserting in place thereof
847 the following:—

848 The secretary, in consultation with the division, shall establish rates of payment for health
849 care services.

850 SECTION 31. Section 3 of chapter 118G as so appearing is hereby amended by striking
851 out said section in its entirety and inserting in place thereof the following:—

852 Section 3. For the purposes set forth in this chapter, the board is authorized and
853 empowered as follows:

854 (a) to develop a plan of operation for the division. The plan of operation shall include, but
855 not be limited to:

856 (1) implementation of procedures for operations of the division; and

857 (2) implementation of procedures for communications with the executive director.

858 (b) to acquire, own, hold, dispose of, and encumber personal property and to lease real
859 property in the exercise of its powers and the performance of its duties.

860 (c) to seek and receive any grant funding from the federal government, departments or
861 agencies of the commonwealth, and private foundations.

862 (d) to enter into and execute instruments in connection with agreements or transactions
863 with any federal, state or municipal agency or other public institution or with any private

864 individual, partnership, firm, corporation, association or other entity, including contracts with
865 professional service firms as may be necessary in its judgment, and to fix their compensation.

866 (e) to adopt by-laws for the regulation of its affairs and the conduct of its business.

867 (f) to adopt an official seal and alter the same.

868 (g) to maintain an office at such place or places in the commonwealth as it may
869 designate.

870 (h) to sue and be sued in its own name, plead and be impleaded.

871 (i) to establish lines of credit, and establish one or more cash and investment accounts to
872 receive payments for services rendered, appropriations from the commonwealth and for all other
873 business activity granted by this chapter except to the extent otherwise limited by any applicable
874 provision of the Employee Retirement Income Security Act of 1974.

875 (j) to approve the use of its trademarks, brand names, seals, logos and similar instruments
876 by participating carriers, employers or organizations.

877 (k) to acquire, own, hold, dispose of, and encumber personal property and to lease real
878 property in the exercise of its powers and the performance of its duties.

879 (l) to maintain a prudent level of reserve funds to protect the solvency of any trust funds
880 under the operation and control of the division.

881 (m) to enter into interdepartmental agreements with the executive office of health and
882 human services, the division of insurance, the department of public health, and any other state
883 agencies the board deems necessary to implement the provisions of this chapter. The division of

884 insurance shall provide any needed information, support, personnel and other assistance to the
885 division in connection with the implementation of the provisions of this chapter but shall not be
886 subject to the control of the division in connection therewith.

887 SECTION 32. Chapter 118G as so appearing is hereby amended by inserting after
888 section 3 the following 2 sections:—

889 Section 3A. (a) The division shall work with other state agencies including, but not
890 limited to, the department of public health and the department of mental health, the division of
891 medical assistance and the division of insurance to collect and publish data concerning the cost
892 of health insurance in the commonwealth and the health status of individuals; hold annual
893 hearings concerning health care provider and payer costs and cost trends, and to provide an
894 analysis of health care spending trends with recommendations for strategies to promote an
895 efficient health delivery system. The division shall make available actual costs of health care
896 services, as supplied by each provider, to the general public in the manner specified in section
897 59 of this chapter.

898 (b) The division shall have the power to design and to revise, consistent with this chapter,
899 a basic schedule of health care services that enrollees in any health insurance program
900 implemented by the division shall be eligible to receive. Such covered services shall include
901 those which typically are included in employer-sponsored health benefit plans in the
902 commonwealth. The division may promulgate schedules of covered health care services which
903 differ from the basic schedule and which apply to specific classes of enrollees. The division may
904 promulgate a schedule of premium contributions, co-payments, co-insurance, and deductibles for
905 said programs, including reduced premiums based on a sliding fee, and other fees and revise

906 them from time to time, subject to the approval of the division of insurance; and provided,
907 however, that such schedule shall provide for such enrollees to pay one hundred per cent of such
908 premium contributions if their income substantially exceeds the non-farm poverty guidelines of
909 the United States office of management and budget.

910 (c) The division shall adopt and amend rules and regulations, in accordance with chapter
911 30A, for the administration of its duties and powers and to effectuate the provisions and purposes
912 of this section. Such regulations shall be adopted, after notice and hearing, only upon
913 consultation with representatives of nonprofit hospital service corporations established under
914 chapter 176A, elected representatives of health systems agencies designated pursuant to Title XV
915 of the federal public health service act, representatives of companies authorized to sell accident
916 and health insurance under chapter 175 and the Massachusetts Hospital Association.

917 Section 3B. The division shall implement the reform of the health care delivery and
918 payment system in the commonwealth in accordance with this chapter. The board shall (i)
919 oversee and regulate the establishment of ACOs;(ii) oversee the development of patient-centered
920 medical homes; (iii) require the adoption of alternative payment methods and health care
921 delivery systems by providers; and (iv) ensure the consistent and effective use by providers of
922 quality measures to promote patient-centered, timely, high-quality and safe care for individuals
923 in the commonwealth.

924 SECTION 33. Section 4 of chapter 118G, as so appearing, is hereby amended by striking
925 out in line 1 the word “commissioner” and inserting in place thereof the following:—executive
926 director

927 SECTION 34. Section 5 of chapter 118G of the General Laws, as so appearing, is hereby
928 repealed.

929 SECTION 35. Section 6 of chapter 118G, as so appearing, is hereby amended by striking
930 the first sentence and inserting in place thereof the following sentence:—

931 The division may promulgate such regulations as necessary to ensure the uniform
932 reporting of revenues, charges, costs, and utilization of health care services and other such data
933 as the division may require of institutional providers and their parent organizations and any other
934 affiliated entities; non-institutional providers including, but not limited to, physician group
935 entities; and ACOs.

936 SECTION 36. Section 6 of chapter 118G of the General Laws, as so appearing, is hereby
937 amended by inserting, in lines 52 and 76, after the words “provider group,” the following
938 words:— , accountable care organization, as defined in chapter 118J, physician organization, as
939 defined in section 53H of chapter 111,

940 SECTION 37. Section 6 of chapter 118G of the General Laws, as so appearing, is hereby
941 further amended by inserting, in lines 54 and 77, after the word “hospital”, the following
942 words:—

943 , accountable care organization, as defined in chapter 118J, physician organization, as
944 defined in section 53H of chapter 111,

945 SECTION 38. Section 6 ½ of chapter 118G of the General Laws, as so appearing, is
946 hereby amended by inserting, in line 62, after the word “technology” the following words:—and
947 the impact of price transparency on prices

948 SECTION 39. Said section 6½ as so appearing, is hereby further amended by inserting,
949 in line 69, after the word “practices” the following words:— the impact of price transparency on
950 prices,

951 SECTION 40. Said section 6½, as so appearing, is hereby further amended by adding at
952 the end thereof the following:—

953 As used in this section, “provider,” shall mean any person, corporation partnership,
954 governmental unit, state institution, accountable care organization, physician organization, or any
955 other entity qualified under the laws of the commonwealth to perform or provide health care
956 services.

957 SECTION 41. Said section 6½, as so appearing, is hereby further amended by striking
958 out, in lines 50 and 51, the words “and (x) any witness identified by the attorney general” and
959 inserting in place thereof the following:—

960 (x) accountable care organizations from separate regions of the state; (xi) physician
961 organizations from at least 3 separate regions of the state; and (xii) any witness identified by the
962 attorney general

963 SECTION 42. Chapter 118G of the General Laws, as so appearing, is hereby amended
964 by striking section 6A, as so appearing, and inserting in place thereof the following section:-

965 Section 6A. (a) In fulfillment of its duties pursuant to clause (a) of the second paragraph
966 of section 2, the division shall collect and analyze such data as it deems necessary in order to
967 better protect the public’s interest in monitoring the financial conditions of acute hospitals. Such
968 information shall be analyzed on an industry-wide and hospital-specific basis and shall include,

969 but not be limited to: (1) gross and net patient service revenues; (2) sources of hospital revenue,
970 including revenue excluded from consideration in the establishment of hospital rates and charges
971 pursuant to section 12; (3) private sector charges; (4) trends in inpatient and outpatient case mix,
972 payor mix, hospital volume and length of stay; (5) total payroll as a percent of operating
973 expenses, as well as the salary and benefits of the top 10 highest compensated employees,
974 identified by position description and specialty; and (6) other relevant measures of financial
975 health or distress.

976 (b) The division shall publish annual reports and establish a continuing program of
977 investigation and study of financial trends in the acute hospital industry, including an analysis of
978 systemic instabilities or inefficiencies that contribute to financial distress in the acute hospital
979 industry. Such reports shall include an identification and examination of hospitals that the
980 division considers to be in financial distress, including any hospitals at risk of closing or
981 discontinuing essential health services, as defined by the department of public health pursuant to
982 section 51G of chapter 111, as a result of financial distress.

983 (c) The division may modify uniform reporting requirements established pursuant to
984 section 6 and may require hospitals to report required information quarterly to effectuate the
985 purposes of this section.

986 SECTION 43. Section 7 of chapter 118G of the General Laws, as so appearing, is hereby
987 amended by inserting, in line 1, after the words “executive office”, the following:— “, in
988 consultation with the division,”

989 SECTION 44. Section 11 of chapter 118G of the General Laws, as so appearing, is
990 hereby amended by adding the following subsection:—

991 (d) Notwithstanding any general or special law to the contrary, the executive office of
992 health and human services shall require Medicaid, any carrier or other entity which contracts
993 with the office of Medicaid to pay for or arrange for the purchase of health care services, the
994 commonwealth care health insurance program established under chapter 118H, any carrier or
995 other entity which contracts with the commonwealth care health insurance program to pay for or
996 arrange for the purchase of health care services, the group insurance commission established
997 under chapter 32A, and any other state sponsored or state managed plan providing health care
998 benefits to reimburse any licensed hospital facility operating in the commonwealth that has been
999 designated as a critical access hospital pursuant to U.S.C. 1395i-4, in an amount equal to at least
1000 101 percent of allowable costs under each such program, as determined by utilizing the Medicare
1001 cost-based reimbursement methodology, for both inpatient and outpatient services provided to
1002 eligible patients of such facility.

1003 SECTION 45. Section 18B of chapter 118G of the General Laws, as so appearing, is
1004 hereby repealed.

1005 SECTION 46. Chapter 118G of the General Laws is hereby amended by striking out the
1006 section 40 in its entirety and inserting in place thereof the following section:-

1007 Section 40. (a) Acute hospitals and ambulatory surgical centers shall be assessed a one-
1008 time surcharge to be paid to the division for the distressed hospital fund, created under section
1009 2DDDD of chapter 29 to be paid by July 1, 2013. The surcharge amount shall equal the product
1010 of (i) the surcharge percentage and (ii) the assessment. The division shall calculate the surcharge
1011 percentage by dividing the acute hospital's patient service revenue by the total patient service
1012 revenues of acute hospitals paying an assessment under this section. The assessment shall equal

1013 the product of (i) the total medical spend in calendar year 2011 and (ii) 0.1 per cent. The division
1014 shall determine the surcharge percentage for the one-time assessment by December 31, 2012. In
1015 the determination of the surcharge percentage, the division shall use the best data available as
1016 determined by the division and may consider the effect on projected surcharge payments of any
1017 modified or waived enforcement pursuant to subsection (g). The division shall incorporate all
1018 adjustments, including, but not limited to, updates or corrections or final settlement amounts, by
1019 prospective adjustment rather than by retrospective payments or assessments. The division may
1020 waive the assessment for an acute hospital or ambulatory surgical center, if it finds the hospital
1021 or ambulatory surgical center is unable to pay the assessment; provided that if an acute hospital
1022 or ambulatory surgical is a part of a system, then the system as a whole shall be financially
1023 reviewed. The division shall make a determination for waiver based on the following factors: (A)
1024 total revenues, (B) total reserves, (C) total profits, margins or surplus, (D) administrative expense
1025 ratio, and (E) the compensation of executive managers and board members. Provided however,
1026 any hospital system with less than \$1,000,000,000 in total net assets and more than 50% of
1027 revenues from public payers shall be exempt from this section.

1028 (b) Surcharge payors shall be assessed a one-time surcharge to be paid to the division for
1029 the distressed hospital fund, created under section 2DDDD of chapter 29 by July 1, 2013. The
1030 surcharge amount shall equal the product of (i) the surcharge percentage and (ii) the assessment.
1031 The division shall calculate the surcharge percentage by dividing the surcharge payor's payments
1032 for acute hospital services by the payment for acute hospital services by all surcharge payors.
1033 The assessment shall equal the product of (i) the total medical spend in calendar year 2011 and
1034 (ii) 0.2 per cent. The division shall determine the surcharge percentage for the one-time
1035 assessment by December 31, 2012. In the determination of the surcharge percentage, the division

1036 shall use the best data available as determined by the division and may consider the effect on
1037 projected surcharge payments of any modified or waived enforcement pursuant to subsection (g).
1038 The division shall incorporate all adjustments, including, but not limited to, updates or
1039 corrections or final settlement amounts, by prospective adjustment rather than by retrospective
1040 payments or assessments. The division may waive the assessment for a payor, if it finds the
1041 payor would not be able to make payment. The division shall take into account the following
1042 factors when determining if a payor is able to pay: (A) total revenues, (B) total premium receipts,
1043 (C) total reserves, (D) total profits, margins or surplus, (E) medical loss ratio and administrative
1044 expense ratio, and (F) the compensation of the executive managers and board members.

1045 (c) The division shall specify by regulation appropriate mechanisms that provide for
1046 determination and payment of an acute hospital, an ambulatory surgical center, or a surcharge
1047 payor's liability, including requirements for data to be submitted by acute hospitals, ambulatory
1048 surgical centers, and surcharge payors.

1049 (d) A hospital's liability to the fund shall in the case of a transfer of ownership be
1050 assumed by the successor in interest to the hospital.

1051 (e) An ambulatory surgical center's liability to the fund shall in the case of a transfer of
1052 ownership be assumed by the successor in interest to the ambulatory surgical center.

1053 (f) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
1054 assumed by the successor in interest to the surcharge payor.

1055 (g) The division shall establish by regulation an appropriate mechanism for enforcing an
1056 acute hospital or surcharge payor's liability to the fund if an acute hospital or surcharge payor
1057 does not make a scheduled payment to the fund; provided, however, that the division may, for

1058 the purpose of administrative simplicity, establish threshold liability amounts below which
1059 enforcement may be modified or waived. Such enforcement mechanism may include assessment
1060 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent
1061 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement
1062 mechanism may also include notification to the office of Medicaid requiring an offset of
1063 payments on the claims of the acute hospital or surcharge payor, any entity under common
1064 ownership or any successor in interest to the acute hospital or surcharge payor, from the office of
1065 Medicaid in the amount of payment owed to the fund including any interest and penalties, and to
1066 transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as
1067 ordered by the division, the office of Medicaid shall be considered not to be in breach of contract
1068 or any other obligation for payment of non-contracted services, and an acute hospital or
1069 surcharge payor whose payment is offset under an order of the division shall serve all Title XIX
1070 recipients under the contract then in effect with the executive office of health and human
1071 services. In no event shall the division direct the office of Medicaid to offset claims unless the
1072 acute hospital or surcharge payor has maintained an outstanding liability to the fund for a period
1073 longer than 45 days and has received proper notice that the division intends to initiate
1074 enforcement actions under regulations promulgated by the division.

1075 (h) If an acute hospital or surcharge payor fails to file any data, statistics or schedules or
1076 other information required under this chapter or by any regulation promulgated by the division,
1077 the division shall provide written notice to the acute hospital or surcharge payor. If an acute
1078 hospital or surcharge payor fails to provide required information within 14 days after the receipt
1079 of written notice, or falsifies the same, he shall be subject to a civil penalty of not more than
1080 \$5,000 for each day on which the violation occurs or continues, which penalty may be assessed

1081 in an action brought on behalf of the commonwealth in any court of competent jurisdiction. The
1082 attorney general shall bring any appropriate action, including injunctive relief, necessary for the
1083 enforcement of this chapter.

1084 (i) Acute hospitals shall not seek an increase in rates to pay for this assessment.

1085 (j) Ambulatory surgical centers shall not seek an increase in rates to pay for this
1086 assessment

1087 (k) Surcharge payors shall not seek an increase in premiums to pay for this assessment.

1088 SECTION 47. Chapter 118G as so appearing is hereby further amended by inserting
1089 after section 41 the following 29 sections:—

1090 Section 42. The division shall:

1091 (a) Take actions necessary to ensure the reform of the health care delivery and payment
1092 system by state and private entities in the commonwealth.

1093 (b) Take actions necessary to promote the establishment of ACOs in accordance with the
1094 requirements of chapter 118J and to ensure consistency and efficacy in the establishment and use
1095 of quality measures throughout the commonwealth to promote patient-centered, timely, safe high
1096 quality care for individuals in the commonwealth. The division shall take all necessary actions to
1097 (i) promote ACOs throughout the commonwealth, (ii) support the transition to alternative
1098 payment methods by all payers, and (iii) protect quality, access and patient choice of primary
1099 care provider and accountable care organization for the residents of the commonwealth.

1100 (c) Adopt regulations and issue administrative bulletins and various other forms of
1101 official guidance concerning:

1102 (1) the establishment of ACOs throughout the commonwealth;

1103 (2) the establishment of the standard quality measure set to be used in the evaluation of
1104 the performance of all providers;

1105 (3) requirements and benchmarks for expanding the use of alternative payment
1106 methodologies and reducing the use of fee-for-service methodologies by payers and providers for
1107 the purpose of adopting alternative payment methods across the health care industry by the dates
1108 established under section 43and for the purposes of lowering annual increases in total medical
1109 expenditures.

1110 (4) standards for alternative payment methodologies to be utilized in contracts between
1111 payers and ACOs and other providers. Such standards shall include, but not be limited to the
1112 requirement that payment levels to providers under alternative payment methodologies shall be
1113 dependent, in part, on the achievement of quality performance and shall include risk adjustment
1114 for health status. All payers shall develop and employ alternative payment methodologies
1115 consistent with the requirements of this chapter. All contracts between payers and ACOs that
1116 contain a provision for shared savings between the provider and the payer may contain a
1117 mechanism to return a percentage of the savings to the ACO particiapants; and

1118 (5) requirements for disclosure to the division of provider costs, and of payments made
1119 by payers to ACOs and other providers.

1120 (d) Monitor compliance by ACOs, providers, and payers with requirements established
1121 pursuant to this chapter and any implementing regulations promulgated by the division;
1122 achievement of benchmarks toward use of global and alternative payment methods by payers;

1123 cost growth trends in the health care sector of the commonwealth's economy; and cost growth
1124 trends under global and alternative payment methods used by payers in the commonwealth;

1125 (e) Hold hearings to determine appropriate cost growth and other benchmarks for the
1126 transition to the use of alternative payment methods, and payment limits for health care services;

1127 (f) Waive any of its requirements to permit and support innovative demonstrations or
1128 pilot programs; provided that such waivers may only be renewed if material savings or
1129 improvements in the delivery and quality of care can be documented, to the satisfaction of the
1130 division.

1131 (g) Allow independent physician associations, physician-hospital organizations, and
1132 various forms of integrated health care organizations and entities to qualify as an ACO if they
1133 meet the criteria as set forth in chapter 118J. The division shall encourage and assist providers
1134 with voluntary adoption of the ACO model of health care service delivery as much as practicable
1135 relative to funding and resources available to the division under this chapter.

1136 (h) Provide by regulation for the certification or licensing of ACOs that meet the
1137 requirements of chapter 118J, and by January 1, 2013 establish by regulation minimum
1138 requirements for the formation of ACOs consistent with the parameters and requirements set
1139 forth in chapter 118J

1140 (i) Monitor the formation of ACOs in the commonwealth, and establish any benchmarks
1141 deemed necessary or appropriate to facilitate the transition of health care providers and facilities
1142 into integrated care delivery systems;

1143 (j) Establish safeguards against underutilization of services and protections against and
1144 penalties for inappropriate denials of services or treatment in connection with utilization of any
1145 alternative payment method or transition to a global payment system;

1146 (k) Establish safeguards against and penalties for inappropriate selection of low cost
1147 patients and avoidance of high cost patients by any provider accepting a risk based contract,
1148 including but not limited to requiring that ACOs accept as ACO patients all individuals
1149 regardless of payer source or clinical profile;

1150 (l) Establish parameters to measure and ensure access by disabled and other individuals
1151 with chronic or complex medical conditions to appropriate specialty care;

1152 (m) Establish reporting and disclosure requirements for ACOs and ACO participants in
1153 accordance with the requirements of chapter 118J.

1154 (n) Consistent with quality measurements and standards established by nationally
1155 recognized professional organizations, establish parameters for clinical outcomes beyond the
1156 control of the clinician for which ACOs and ACO participants shall not be financially
1157 responsible;

1158 (o) Monitor ACO delivery systems paid under alternative payment methods to ensure that
1159 ACOs possess either internally or through contract arrangements the competencies necessary to
1160 operate as an effective ACO;

1161 (p) Evaluate and provide guidance through regulations relative to consumer protections
1162 and any deficiencies of patient choice of provider that may arise in the transition from a fee-for-
1163 service system. The division shall monitor the movement of patients from and between ACOs,

1164 and shall establish parameters for out-of-ACO arrangements, as well as for patient provider
1165 choice and other consumer protections;

1166 (q) Establish by regulation requirements for ACOs to address consumer grievances.

1167 (r) Review and evaluate provider and payer complaints, and establish by regulation
1168 requirements for ACOs to address provider grievances;

1169 (s) Oversee compliance by ACOs, providers, and payers with requirements established
1170 pursuant to this chapter and any implementing regulations promulgated by the division; barriers
1171 to entry by providers; excess consolidation of ACOs or other integrated services provider groups;
1172 and the trends in patient choice of providers and ACOs;

1173 (t) Ensure that all data collection, analysis, and other submission requirements
1174 established under this chapter are implemented in a manner which promotes administrative
1175 simplification, avoids duplication, and does not impose an undue burden on any entity or
1176 individual;

1177 (u) Provide guidance to ACOs and providers seeking to form an ACO, upon request or on
1178 its own initiative, on the potential implications of 42 U.S.C. section 1320a -7b and implementing
1179 regulations, and 42 U.S.C. section 1395nn(a) to (e) and implementing regulations in connection
1180 with such arrangements;

1181 (v) If any ACO, payer or provider fails to comply with any requirement of this chapter or
1182 chapter 118J, including failure to meet medical cost growth targets as provided in section 46, to
1183 implement alternative payment methods by the dates established in section 43, to implement
1184 required health information technology by the dates established in chapter 118I, or to submit

1185 required reports or data as required in section 50, the division shall impose a penalties as
1186 provided in this chapter.

1187 (w) Implement a state-wide inter-operable patient health information exchange no later
1188 than January 1, 2017. The health information exchange shall include appropriate privacy and
1189 security safeguards.

1190 (x) Determine and specify in regulation the amount of revenue at risk under shared
1191 financial responsibility arrangements, the standards for quality assessments and shared savings or
1192 shared responsibility thresholds.

1193 This section shall be construed in a manner consistent with any applicable federal laws or
1194 regulations governing ACOs, except as otherwise explicitly provided in this chapter or in the
1195 regulations adopted under it.

1196 Section 43. (a) Commencing no later than January 1, 2014, the group insurance
1197 commission, the commonwealth health insurance connector authority, and any other state funded
1198 insurance program shall, to the maximum extent feasible, implement alternative payment
1199 methodologies.

1200 (b) The executive office of health and human services shall seek a federal waiver of
1201 statutory provisions necessary to permit Medicare to participate in such alternative payment
1202 methodologies and use integrated care organizations and ACOs. Upon obtaining federal
1203 approval for Medicare participation, such participation shall be commenced and continued and
1204 the executive office shall seek extensions or additional approvals, as necessary.

1205 (c) Commencing no later than January 1, 2015, private health plans shall, to the
1206 maximum extent feasible, implement alternative payment methodologies. Private health plans
1207 may seek a waiver from the division in order to use a different innovative system, provided,
1208 however, that the health plan seeking the waiver must demonstrate to the satisfaction of the
1209 division that any such system will provide the same level of incentives, risk sharing and cost-
1210 savings as the alternative payment methodologies defined in regulations of the division.

1211 (d) Any provider with 15,000 or more patients must establish that a sufficient portion of
1212 such provider's revenue is derived from contracts with risk-sharing provisions, as defined in
1213 regulations of the division.

1214 (e) Any alternative payment methodology shall include a risk adjustment based on health
1215 status. The division shall create standards for the calculation of risk adjustments and update those
1216 standards on an annual basis. In establishing risk adjustment standards, the division may take
1217 into account functional status, socioeconomic, or cultural factors.

1218 Section 44. Providers and payers who have not implemented compliant alternative
1219 payment methodologies by the date required in section 43, and who have not obtained a waiver
1220 under the provisions of subsection (c) of section 43, shall be subject to a penalty of \$1 per
1221 member per month for the period of time during which such provider or payer is not in
1222 compliance. The division shall assess and collect the penalties as provided in this section.

1223 Section 45. (a) By January 1, 2013, the division, in consultation with the office of
1224 Medicaid, shall develop and implement standards of certification for patient-centered medical
1225 homes. In developing these standards, the division shall consider existing standards by the
1226 National Committee for Quality Assurance or other independent accrediting and medical home

1227 organizations. The standards developed by the division shall include, but not limited to, the
1228 following criteria:

1229 (1) Emphasize, enhance, and encourage the use of primary care including prevention and
1230 wellness;

1231 (2) Focus on delivering high-quality, efficient, and effective health care services;

1232 (3) Enhance access to routine care, urgent care, and clinical advice through means such as
1233 implementing shared appointments, open scheduling, and after-hours care.

1234 (4) Encourage patient-centered care, including active participation by the patient and
1235 family or legal guardian in decision making and care plan development;

1236 (5) Provide patients with a consistent, ongoing contact with a provider or team of
1237 providers to ensure continuous and appropriate care for the patient's condition;

1238 (6) Emphasize a multi-disciplinary team-based approach to care;

1239 (7) Ensure care coordination across settings, including referral and transition
1240 management;

1241 (8) Ensure that patient-centered medical homes develop and maintain appropriate
1242 comprehensive care plans for their patients with complex or chronic conditions, including an
1243 assessment of health risks and chronic conditions;

1244 (9) Enable and encourage utilization of a range of qualified health care professionals,
1245 including dedicated care coordinators, which may include, but not be limited to nurse

1246 practitioners, physician assistants and social workers, in a manner that enables providers to
1247 practice to the fullest extent of their license;

1248 (10) Ensure the use of health information technology and systematic follow-up, including
1249 the use of patient registries; and

1250 (11) Encourage the use of scientifically based health care, shared decision-making aids
1251 that provide patients with information about treatment options and their associated benefits,
1252 risks, costs, and comparative outcomes, and other clinical decision support tools, including but
1253 not limited to decision aids on long-term care and supports and palliative care.

1254 In developing these standards, the division may consult with national and local
1255 organizations working on medical home models, relevant state agencies, health plans,
1256 physicians, nurse practitioners, behavioral health providers, hospitals, social workers, other
1257 health care providers and consumers.

1258 (b) A primary care provider may be certified as a patient-centered medical home. In order
1259 to be certified as a patient-centered medical home, a primary care provider must meet the
1260 standards set by the division in accordance with this section.

1261 (c) A behavioral health provider may be certified as a patient-centered medical home,
1262 provided that the behavioral health provider addresses the majority of the needs of patients with
1263 significant behavioral health diagnoses requiring the provider's expertise. Such a provider may
1264 serve as a medical home for individuals with significant behavioral health diagnoses. In order to
1265 be certified as a patient-centered medical home, a behavioral health provider must meet the
1266 standards set by the division in accordance with this section.

1267 (d) A specialty care provider may be certified as a patient-centered medical home,
1268 provided that the specialty care provider addresses the majority of the needs of patients with
1269 chronic conditions requiring the specialist's expertise. Such a provider may serve as a medical
1270 home for individuals with chronic conditions requiring the specialist's expertise. In order to be
1271 certified as a patient-centered medical home, a specialty care provider must meet the standards
1272 set by the division in accordance with this section.

1273 (e) Certification as a patient-centered medical home is voluntary. Primary care providers,
1274 behavioral health providers, and specialty care providers shall annually renew their certification
1275 as a patient centered medical home.

1276 (f) A primary care provider or specialty-care provider certified as a patient-centered
1277 medical home shall have the ability to assess and provide or arrange for, and coordinate care
1278 with mental health and substance abuse services, to an extent determined by the division. A
1279 behavioral health provider or specialty care provider certified as a patient-centered medical home
1280 shall have the ability to assess and provide or arrange for, and coordinate care with primary care
1281 services, to an extent determined by the division.

1282 (g) Primary care providers, behavioral health providers, or specialty care providers
1283 certified as patient-centered medical homes shall offer their medical home services to all their
1284 patients, including those with chronic medical or behavioral health conditions, who are interested
1285 in participation.

1286 (h) By July 1, 2013, the division, in consultation with the office of Medicaid, shall
1287 establish a patient-centered medical home training cooperative to provide an opportunity for

1288 patient-centered medical homes to learn the core competencies of the patient-centered medical
1289 home model, and exchange information related to quality improvement and best practices.

1290 (i) Patient-centered medical homes shall participate in the patient-centered medical home
1291 learning training cooperative established under subsection (h).

1292 (j) For continued certification under this section, patient-centered medical homes shall
1293 meet quality standards as under the standard quality measure set, as established by section 68 of
1294 chapter 118G. The division shall collect data from patient-centered medical homes necessary for
1295 monitoring compliance with certifications standards and for evaluating the impact of patient-
1296 centered medical homes on health care quality, cost, and outcomes. The division may contract
1297 with a private entity to perform an evaluation of the effectiveness of patient-centered medical
1298 homes.

1299 (k) In providing after-hours care, a medical home may enter into a cooperative
1300 agreement with another medical home, primary care practice, limited service clinic, as defined
1301 by department of public health, or urgent care center to provide after-hours care for their
1302 patients.

1303 (l) The division shall develop a standard payment system for patient-centered medical
1304 homes certified under this section. In developing the standard payment system, the division shall
1305 consider, but not be limited to, per-patient payments, payment levels based on care-complexity,
1306 and payments for care coordination, clinical management, quality performance, and shared
1307 savings. Development of the standard patient-centered medical home payment system shall be
1308 completed by January 1, 2013.

1309 (m) Payers shall make payments to patient-centered medical homes pursuant to the
1310 standard patient-centered medical home payment system established under subsection (l) for
1311 network providers certified as patient-centered medical homes under this section, or an
1312 equivalent as approved by the authority. Medical home payments shall be in addition to any
1313 other payments, such as fee-for-service, global, and bundled payments. Subject to the other
1314 provisions of this legislation, final patient-centered medical home payment amounts shall be
1315 determined through contracts between payors and providers.

1316 (n) The division shall develop and distribute a directory of key, existing referral systems
1317 and resources that can assist patients in obtaining housing, food, transportation, child care, elder
1318 services, long-term care services, peer services, and other community-based services. This
1319 directory shall be made available to patient-centered medical homes in order to connect patients
1320 to services in their community.

1321 (n) Nothing in this section shall preclude the continuation of existing patient-centered
1322 medical home or medical home programs currently operating or under development.

1323 Section 46. (a) The division shall determine and establish the per capita total medical
1324 expense, as defined in section 1, for calendar year 2011, of all providers in the commonwealth
1325 for health care services provided to residents of the commonwealth. The per capita total medical
1326 expense as determined for calendar year 2011 shall be known as the “state base amount.”

1327 (b) The following cost growth targets for per capita total medical expense in the
1328 commonwealth are hereby established:

1329 (i) For calendar year 2015, the target for the per capita total medical expense shall be
1330 an amount equal to the state base amount established in accordance with the provisions of

1331 subsection (a) plus an amount equal to the projected percentage increase in per capita potential
1332 gross state product between calendar year 2011 and calendar year 2015 multiplied by the state
1333 base amount. The percentage increase in per capita potential gross state product between
1334 calendar year 2011 and 2015 shall be calculated based on the formula provided in (b) (ii).

1335 (ii) As part of the governor's annual budget submission, the secretary for
1336 administration and finance shall publish the projected percentage increase in per capita potential
1337 gross state product for the calendar year beginning on January 1 following the budget
1338 submission. For the purposes of clause (i), the projected percentage increase in per capita
1339 potential gross state product for calendar years 2012 and 2013 is 3.6%, and the projected
1340 percentage increase in per capita potential gross state product for 2014 and 2015 shall be
1341 included in the governor's budget submissions for fiscal years 2014 and 2015, respectively.

1342 (iii) For calendar years 2016 through 2026, the target for per capita total medical
1343 expense shall be an amount equal to the per capita total medical expense target established for
1344 the previous calendar year plus an amount equal to the projected percentage rate of increase in
1345 per capita potential gross state product for the current calendar year minus 0.5 per cent multiplied
1346 by the target for the previous calendar year. The target amount is therefore the result of the
1347 cumulative growth of the state base amount, based on the formula provided in clause (ii) and this
1348 clause (iii).

1349 (iv) For calendar years 2027 and subsequent years, the target for the per capita total
1350 medical expense shall be an amount equal to the per capita total medical expense target
1351 established for the previous calendar year plus an amount equal to the projected percentage rate
1352 increase in per capita potential gross state product for the current calendar year plus 1 per cent

1353 multiplied by the target for the previous calendar year. The target amount is therefore the result
1354 of the cumulative growth of the state base amount, based on the formula provided in clause (ii),
1355 clause (iii), and this clause (iv).

1356 (c) In addition to calculating the statewide per capita total medical expense target, the
1357 division shall also determine and report annually the per capita risk adjusted total medical
1358 expenses for residents divided into 3 geographic regions, as determined by the division.

1359 (d) The division shall also determine and report annually the per capita risk adjusted total
1360 medical expenses for each payer in the commonwealth for services delivered to residents in
1361 Massachusetts based on each such payer's combined fully-insured business and administrative
1362 services business.

1363 (e) The division shall also determine and report annually the per capita risk adjusted total
1364 medical expense for each type of payer contract including contracts with accountable care
1365 organizations and other contracts as the division deems appropriate.

1366 (f) The division shall also determine and report annually the per capita risk adjusted total
1367 medical expense across all payers in the commonwealth for each of the following types of
1368 services for services delivered to residents of Massachusetts in Massachusetts:—

1369 (i) Primary care related services.

1370 (ii) preventable emergency department and hospital use, specialist services, imaging and
1371 laboratory testing.

1372 (iii) Services provided by high cost providers such as teaching hospitals.

1373 (iv) Behavioral health services.

1374 (v) Services associated with poor quality including but not limited to hospital
1375 readmissions and hospital acquired infections.

1376 (g) For the purposes of this section, the board shall determine the appropriate
1377 methodology for performing risk-adjustment.

1378 Section 47. (a) Within 180 days of the end of each calendar year, the division shall
1379 conduct a review of the growth in state per capita total medical expense and determine whether
1380 such growth is within or exceeds the target growth for such calendar year. Whether or not the
1381 target has been exceeded, the division shall review and analyze the per capita total medical
1382 expense data for the 3 regions as provided in subsection (b) of section 46, the per capita total
1383 medical expense data for payers as provided in subsection (c) of said section, the per capita total
1384 medical expense data for each type of payer contract as provided in subsection (d) of said section
1385 and the per capita total medical expense data for each of the types of services specified in
1386 subsection (e) of said section.

1387 (b) If the per capita total medical expense in the commonwealth, as determined under
1388 section 46, exceeds the target established for such calendar year, the division shall make a
1389 determination as to the cause or causes of the excess increase. If the division determines that the
1390 increase is caused in whole or in part by circumstances beyond the control of providers or
1391 payers, the division may elect to take no action with respect to any provider or payer.

1392 (c) If the per capita total medical expense of all providers in the commonwealth, as
1393 determined under section 46, exceeds the target established for a calendar year, the division may
1394 undertake actions, including but not limited to the following:

1395 (i) The division may make changes to alternative payment methodologies as authorized
1396 in this chapter in order to further enhance the ability of the state to meet spending targets;

1397 (ii) The division may require payers and providers to implement a corrective action plan.
1398 The correction action plan shall be described in a document outlining the steps that the payer or
1399 provider intends to take to reach compliance with spending targets within the next 18 months. If
1400 the division requires a corrective action plan, the plan shall be submitted to the division within 3
1401 months of notice to the payer or provider. The division shall review and approve or disapprove
1402 the plan within 3 months of submission. The division may require the payer or provider to
1403 submit revisions to the corrective action plan. The payer or provider shall commence
1404 implementation of the corrective action plan promptly upon receiving notice of approval of the
1405 plan.

1406 (iii) The division may require payers and providers to reopen contracts that, in the
1407 division's opinion, are contributing to excessive spending growth;

1408 (iv) The division may submit a recommendation for proposed legislation to the joint
1409 committee on health care financing if the division believes that further legislative authority is
1410 needed to achieve the health care quality and spending sustainability objectives of this act.

1411 (d) The division shall annually review the per capita risk adjusted total medical expenses
1412 for payer and payer contracts as determined under section 46, if the division determines that the
1413 rate of increase in per capita risk adjusted total medical expense for a payer or payer contract has
1414 exceeded the cost growth target for the year or is otherwise deemed to be excessive under the
1415 circumstances and that this increase is likely to threaten the ability of the commonwealth to meet
1416 its spending targets in the current year or a future year, the division may take any of the steps

1417 specified in subpart (c). In addition, as appropriate, the division may refer the payer to the
1418 division of insurance or attorney general for further review and appropriate action. A payer or
1419 payer contract may be subject to action or penalty under this section regardless of whether the
1420 statewide per capita total medical expense growth target for that year has been exceeded by other
1421 contracts.

1422 (e) In deciding whether to take action under subparts (c) and (d), the division shall
1423 consider whether such action will enhance the ability of the commonwealth to achieve the health
1424 care quality and spending sustainability objectives of this act.

1425 (f) If the division determines that per capita total medical expense targets or penalties
1426 should be modified, the division shall submit a recommendation for proposed legislation to the
1427 joint committee on health care financing.

1428 Section 48. (a) Every provider shall be subject to market impact review by the division.
1429 The division shall establish by regulation rules for conducting market impact reviews. Such rules
1430 shall define primary service areas and dispersed service areas based on the geographic capacity
1431 of major service categories. The division may conduct a market impact review for provider
1432 when the division determines that market impact review is in the public interest. The division
1433 shall conduct a market impact review for any provider whose market concentration in primary or
1434 dispersed service areas exceeds the antitrust safety zone as set forth in Federal Trade
1435 Commission and Department of Justice Antitrust Division in the final policy statement of
1436 antitrust enforcement policy regarding accountable care organizations participating in the
1437 Medicare shared savings program, 76 FR 67026 et seq. [verify citation]. The division shall
1438 initiate a market impact review by sending such provider a notice of a market impact review

1439 which shall detail the particular factors that it seeks to examine through the review. The division
1440 shall specify by regulation the procedure for conducting the market impact review.

1441 (b) A market impact review may examine factors including, but not limited to: (1) the
1442 provider's size and market share by major service category within its primary service areas and
1443 dispersed service areas, (2) provider price, including its relative prices filed with the division of
1444 insurance pursuant to chapter 176S, (3) provider quality, including patient experience, (4) the
1445 availability and accessibility of services similar to those provided, or proposed to be provided,
1446 through the organization within its primary service areas and dispersed service areas, (5) the
1447 provider's impact on competing options for the delivery of health care services within its primary
1448 service areas and dispersed service areas, (6) the methods used by the organization to attract
1449 patient volume and to recruit or acquire health care professionals or facilities, (7) the role of the
1450 provider in serving at-risk, underserved, and government payer patient populations within its
1451 primary service areas and dispersed service areas, (8) the role of the provider organization in
1452 providing low margin or negative margin services within its primary service areas and dispersed
1453 service areas, (9) the financial solvency of the provider, (10) consumer concerns, including but
1454 not limited to complaints or other allegations that the provider has engaged in any unfair method
1455 of competition or any unfair or deceptive act or practice, and (11) any other factors that the
1456 division determines to be in the public interest.

1457 (c) The department of public health shall submit information to the division regarding
1458 any proposed projects, mergers or acquisitions that will result in a substantial capital expenditure
1459 or substantial change in services under determination of need with respect to a provider.

1460 (d) If after completing a market impact review, the division determines that a substantial
1461 capital expenditure or substantial change in services has resulted or would result in any unfair
1462 method of competition, any unfair or deceptive act or practice, as defined in chapter 93A, or
1463 determines that a proposed project, merger or acquisition will result in a material change under
1464 determination of need that would result in any unfair method of competition, any unfair or
1465 deceptive act or practice, the division shall refer its findings, together with any supporting
1466 documents, data or information to the attorney general for further review and action.

1467 Section 49. (a) The division shall promote transparency of prices and quality in the
1468 health care system to enable payers, providers, employers, and consumers to make informed
1469 decisions, facilitate the coordination of care, and monitor the commonwealth's progress in
1470 reducing overall health care costs. For this purpose, the division shall:—

1471 (i) Establish and monitor goals and benchmarks for reducing health care costs,
1472 improving the quality of the health care system and increasing access to care in the
1473 commonwealth;

1474 (ii) Oversee the collection of data from health care providers, payers and consumers
1475 on the cost, quantity, and quality of health care delivered in the commonwealth;

1476 (iii) Specify what data shall be reported and the frequency and manner of reporting;

1477 (iv) Analyze such data to identify health care cost trends and the impact of the
1478 transition from fee-for-service to alternative payment methodologies;

1479 (v) Report to consumers comparative health care price and quality information
1480 through the consumer health education website established under 59 ;

1481 (vi) Commission an annual independent survey of patient and caregiver experience
1482 and satisfaction with the health care system, taking into account care provided by primary care
1483 providers, hospitals, accountable care organizations and other care networks. The survey shall
1484 also assess patients' perceptions on their access to services, including, but not limited to, mental
1485 health and primary care; patients' perceptions of the impact of health insurance premiums and
1486 out-of-pocket expenditures on access to care and affording other necessities; the experience of
1487 vulnerable populations such as the homeless, those with disabilities, women, the elderly and
1488 children; and differences in experience by racial, ethnic and socioeconomic background; and

1489 (vii) Publish reports on the cost, quantity, and quality of health care delivered in the
1490 commonwealth. Such reports shall include, but are not limited to,

1491 A. an initial report that establishes a baseline of the current health care delivery
1492 system in the commonwealth in terms of cost, quality and utilization and market power;

1493 B. an annual report on the implementation of payment reform which shall include,
1494 but not be limited to: the achievement of benchmarks for the reduction of health care costs,
1495 improvement in quality and increased access to care, analyzed by region of the state and resident
1496 demographics; the number, proportion and type of providers affiliating with an accountable care
1497 organization; and performance of accountable care organizations.

1498 C. the proportion of health care expenditures reimbursed under fee-for-service and
1499 alternative payment methodologies; the proportion of patients receiving care inside of an
1500 accountable care organization; the barriers of entry, if any, for an accountable care organization;
1501 the status of patient choice of provider and accountable care organization; and trends in total
1502 medical spending including, but not limited to, cost growth trends for fee-for-service rates and

1503 alternative payment methodologies; cost growth trends for care provided within accountable care
1504 organizations and care provided outside of accountable care organizations; and cost growth
1505 trends by provider sector, including, but not limited to, hospitals, hospital systems, non-acute
1506 providers, prescription drugs, and durable medical equipment; and

1507 D. an annual evaluation of the patient-centered medical home model, as established
1508 under section 45, which shall include, but not be limited to: the number of patients in the
1509 commonwealth in patient-centered medical homes and the number and characteristics of
1510 enrollees with complex or chronic conditions, indentified by income, race, ethnicity and
1511 language; the number and geographic distribution of patient-centered medical home providers;
1512 the performance and quality of patient-centered medical homes; measures of preventive care;
1513 patient-centered medical home payment arrangements, and costs related to implementation and
1514 patient-centered medical home payment fees; the estimated impact of patient-centered medical
1515 homes on health disparities; and estimated savings from implementation of the patient-centered
1516 medical home model on the health care system.

1517 (c) The division shall ensure that all data collection, analysis, and other submission
1518 requirements established under this section are implemented in a manner that promotes
1519 administrative simplification and avoids duplication.

1520 (d) The division shall ensure compliance with all state and federal privacy requirements,
1521 including those imposed by the Health Insurance Portability and Accountability Act of 1996,
1522 P.L. 104-191, the American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§
1523 2.11 et seq., and 45 C.F.R. §§ 160, 162 and 164.

1524 (e) The division shall promulgate regulations necessary for the implementation of the
1525 requirements of this section.

1526 Section 50. (a) To facilitate the sharing of health care data between payers, providers,
1527 employers, and consumers, the division shall:—

1528 (i) Establish procedures for payers to report to members their out-of-pocket costs,
1529 including, but not limited to, requiring payers to provide a toll-free number and website that
1530 enables consumers to request and obtain from a payer in real time the maximum estimated
1531 amount the insured will be responsible to pay for a proposed admission, procedure or service that
1532 is a medically necessary covered benefit, based on the information available to the carrier at the
1533 time the request is made, including any copayment, deductible, coinsurance or other out of
1534 pocket amount, for any health care benefits;

1535 (ii) Establish procedures for the authority to disclose to providers, on a timely basis,
1536 the contracted prices of individual health care services so as to aid in patient referrals and the
1537 management of alternative payment methodologies. Contracted prices shall be listed by provider
1538 and payer;

1539 (iii) Establish procedures for payers to disclose patient-level data including, but not
1540 limited to, health care service utilization, medical expenses, demographics, and where services
1541 are being provided, to all providers in their network, provided that data shall be limited to
1542 patients treated by that provider, so as to aid providers in managing the care of their own patient
1543 panel;

1544 (iv) Establish procedures for third-party administrators to disclose to self-insured
1545 group clients the prices and quality of services of in-network providers; and

1546 (v) Establish procedures for health care providers, upon the request of a patient or
1547 prospective patient, to disclose the charges, and if available, the allowed amount, or where it is
1548 not possible to quote a specific amount in advance due to the health care provider's inability to
1549 predict the specific treatment or diagnostic code, the estimated charges or estimated allowed
1550 amount for a proposed admission, procedure or service.

1551 (b) The division shall ensure that all data collection, analysis, and other submission
1552 requirements established under this section are implemented in a manner that promotes
1553 administrative simplification and avoids duplication.

1554 (c) The division shall ensure the timely reporting of information required under this
1555 section. The division may assess penalties against any reporting entity that fails to meet a
1556 reporting deadline, said funds shall be deposited into the wellness and prevention trust fund, as
1557 established in section 75 of chapter 10.

1558 Section 51. (a) A payer or any entity acting for a payer under contract, when requiring
1559 prior authorization for a health care service or benefit, shall use and accept only the prior
1560 authorization forms designated for the specific types of services and benefits developed pursuant
1561 to subsection (c).

1562 (b) If a payer or any entity acting for a payer under contract fails to use or accept the
1563 required prior authorization form, or fails to respond within 2 business days after receiving a
1564 completed prior authorization request from a provider, pursuant to the submission of the prior
1565 authorization form developed as described in subsection (c), the prior authorization request shall
1566 be deemed to have been granted.

1567 (c) The division shall develop and implement uniform prior authorization forms for
1568 different health care services and benefits by July 1, 2013. The forms shall cover such health
1569 care services and benefits including but not limited to provider office visits, prescription drug
1570 benefits, imaging and other diagnostic testing, laboratory testing and any other health care
1571 services. The division shall develop forms for different kinds of services as it deems necessary
1572 or appropriate provided that all payers and any entities acting for a payer under contract must use
1573 the uniform form designated by the division for the specific type of service. Six months after the
1574 full set of forms is developed, every provider shall use the appropriate uniform prior
1575 authorization form to request prior authorization for coverage of the health care service or benefit
1576 and every payer or any entity acting for a payer under contract shall accept the form as sufficient
1577 to request prior authorization for the health care service or benefit.

1578 (d) The prior authorization forms developed pursuant to subdivision (c) shall meet the
1579 following criteria:

1580 (1) The forms shall not exceed two pages;

1581 (2) The forms shall be made electronically available;

1582 (3) The payer must be able to electronically accept the completed forms;

1583 (4) The division, in developing the forms, shall seek input from interested stakeholders;

1584 (5) The division shall ensure that the forms are consistent with existing prior
1585 authorization forms established by the federal Centers for Medicare and Medicaid Services; and

1586 (6) The division, in developing the forms, shall consider other national standards
1587 pertaining to electronic prior authorization.

1588 Section 52. The division shall establish standardized processes and procedures applicable
1589 to all health care providers and payers for the determination of a patient's health benefit plan
1590 eligibility at or prior to the time of service by July 1, 2013. As part of such processes and
1591 procedures, the division shall (i) require payers to implement automated approval systems such
1592 as decision support software in place of telephone approvals for specific types of services
1593 specified by the division and (ii) require establishment of an electronic data exchange to allow
1594 providers to determine eligibility at or prior to the point of care.

1595 Section 53. The division shall develop a summary of payments form to be used by all
1596 health care payers in the commonwealth that is provided to health care consumers with respect to
1597 provider claims submitted to a payer and written in an easily readable and understandable format
1598 showing the consumer's responsibility, if any, for payment of any portion of a health care
1599 provider claim by July 1, 2013. The summary of payments form shall include the following
1600 information: (i) provider charges; (ii) contracted rate or allowed amount; (iii) the payment made
1601 by the payer; (iv) the co-pay paid by the consumer; (v) the amount subject to a deductible; and
1602 (vi) any other amount not covered by the payer for which the consumer is responsible, including
1603 co-insurance. The division shall promulgate regulations to implement the requirements of this
1604 section no later than July 1, 2013.

1605 Section 54. The division shall coordinate among state agencies the streamlining and
1606 simplification of state health care data reporting requirements and make recommendations to the
1607 joint committee on health care financing for any necessary legislation to further such
1608 simplification.

1609 Section 55. (a) The division shall require accountable care organizations to provide
1610 financial data on an annual basis before April 1. The division may require information related to
1611 its 1) annual receipts, 2) annual costs, 3) realized capital gains and losses, 4) accumulated
1612 surplus, 5) accumulated reserves, 6) administrative expenses, 7) marketing expenses, 8)
1613 charitable expenses, and 9) any other information deemed necessary by the division.

1614 (b) An accountable care organization who fails to submit such statement before April 1
1615 shall be assessed a late penalty not to exceed \$100 per day. Amounts pursuant to this section
1616 shall be deposited to the Wellness and Prevention Trust Fund established under section 75 of
1617 chapter 10 of the General Laws . The division shall make public all of the information collected
1618 under this section. The division shall, from time to time, require accountable care organizations
1619 to submit the underlying data used in their calculations for audit.

1620 The division may adopt rules to carry out this subsection and criteria for the standardized
1621 reporting and uniform allocation methodologies among accountable care organizations. The
1622 division shall, before adopting regulations under this subsection, consult with other agencies of
1623 the commonwealth and the federal government and affected carriers to ensure that the reporting
1624 requirements imposed under the regulations are not duplicative.

1625 Section 56. (a) The division shall calculate a statewide median contracted price for each
1626 health care service provided by hospitals, physician groups, other health care providers licensed
1627 under chapter 112 of the General Laws, and free standing surgical centers. The division shall
1628 establish a uniform methodology to collect all necessary information to calculate such prices.
1629 The statewide median contracted price shall be calculated on an annual basis.

1630 (b) The division shall also calculate a provider-specific average contracted price relative
1631 to the statewide median contracted price for a comparable set of services, based on a weighting
1632 formula to be determined by the division. The division shall also calculate a provider-specific
1633 measure of the total units of service provided, based on a weighting formula to be determined by
1634 the division.

1635 (c) Any hospital, physician group, other health care provider licensed under chapter 112
1636 of the General Laws, and free standing surgical center shall be assessed a surcharge if their
1637 contracted average price exceeds 120 percent of the comparable statewide median contracted
1638 price.

1639 (d) The surcharge amount shall be equal to the product of (i) the surplus amount and (ii)
1640 10 per cent. The surplus amount shall be equal to the units of comparable services provided
1641 multiplied by the difference between the provider-specific average contracted price and the
1642 statewide median contracted price for the comparable set of services. The division shall exempt
1643 units of service from the surcharge if (1) said service has limited or exclusive availability in the
1644 commonwealth, as determined by the division or (2) the division determines that the quality of
1645 the service is reasonably related to the price.

1646 (e) The assessment shall be paid to the division on a quarterly basis. The funds from the
1647 assessment shall be placed in the distressed hospital trust fund, as established under section
1648 2DDDD of chapter 29.

1649 (f) Providers are prohibited from passing along the costs of this surcharge to consumers.

1650 (f) Failure to report or pay the division in a timely fashion shall result in an interest
1651 charge at an annual rate equal to the weekly average 1-year constant maturity Treasury yield plus

1652 4 per cent, as published by the Board of Governors of the Federal Reserve System for the
1653 calendar week preceding the date of non-compliance.

1654 (g) The division shall promulgate all necessary regulations to implement this section.

1655 Section 57. (a) Third party administrators of self-funded plans shall implement alternative
1656 payment methods in accordance with this chapter and all other laws. With the input of expert
1657 advice, the division shall evaluate and take measures to address ERISA restrictions and
1658 recommend potential incentives for employers who participate in self-funded plans to participate
1659 in alternative payment methods.

1660 Section 58. (a) The division shall disseminate the data it collects under this section to
1661 consumers, health care providers and payers through: (i) a publicly-accessible consumer health
1662 information website; (ii) reports on performance provided to health care providers; and (iii) any
1663 other analysis and reporting the council deems appropriate.

1664 When collecting data, the division shall, to the extent possible, utilize existing public and
1665 private data sources and agency processes for data collection, analysis and technical assistance.
1666 The division may enter into an interagency service agreement with other state agencies for data
1667 collection analysis and technical assistance.

1668 The division may, subject to chapter 30B, contract with an independent health care
1669 organization for data collection, analysis or technical assistance related to its duties; provided,
1670 however, that the organization has a history of demonstrating the skill and expertise necessary to:
1671 (i) collect, analyze and aggregate data related to quality and cost across the health care system;
1672 (ii) identify quality improvement areas through data analysis; (iii) work with Medicare,
1673 MassHealth, and other insurers' data; (iv) collaborate in the design and implementation of

1674 quality improvement and clinical performance measures; (v) establish and maintain security
1675 measures necessary to maintain confidentiality and preserve the integrity of the data; and (vii)
1676 identify and, when necessary, develop appropriate measures of quality and cost for public
1677 reporting of quality and cost information.

1678 Payers and health care providers shall submit data to the division or an independent
1679 health care organization with which the division has contracted, as required by the division's
1680 regulations. The division, through its rules and regulations, may determine what type of data may
1681 reasonably be required and the format in which it shall be provided.

1682 The division may request that third-party administrators submit data to the division or to
1683 an independent health care organization with which the council has contracted. The division,
1684 through its rules and regulations, may determine the format in which the data shall be provided.
1685 The division shall publicly post a list of third-party administrators that refuse to submit requested
1686 data.

1687 If any payer or health care provider fails to submit required data to the council on a
1688 timely basis, the council shall provide written notice to the payer or health care provider. A payer
1689 or health care provider that fails, without just cause, to provide the required information within 2
1690 weeks following receipt of the written notice may be required to pay a penalty of \$1,000 for each
1691 week of delay; provided, however, that the maximum annual penalty under this section shall be
1692 \$50,000.

1693 (b) The division, through its rules and regulations, shall provide access to data it collects
1694 pursuant to this section. Access to data shall include, but not be limited to, disclosing to
1695 providers, on a timely basis, the contracted prices of individual health care services so as to aid

1696 in patient referrals and the management of alternative payment methodologies. Contracted prices
1697 shall be listed by provider and payer. The division shall provide data under conditions that: (i)
1698 protect patient privacy; (ii) prevent collusion or anti-competitive conduct; and (iii) prevent the
1699 release of data that could reasonably be expected to increase the cost of health care. The division
1700 may limit access to data based on its proposed use, the credentials of the requesting party, the
1701 type of data requested or other criteria required to make a determination regarding the
1702 appropriate release of the data. The division shall also limit the requesting party's use and release
1703 of any data to which that party has been given access by the division. The division shall maintain
1704 a database of health care claims submitted pursuant to this section for the purpose of conducting
1705 data analysis and preparing reports to assist in the formulation of health care policy and the
1706 provisions and purchase of health care services.

1707 Data collected by the division under this section shall not be a public record under clause
1708 twenty-sixth of section 7 of chapter 4 or under chapter 66, except as specifically otherwise
1709 provided by the council.

1710 The division shall, through interagency service agreements, allow the use of its data by
1711 other state agencies for review and evaluation of mandated health benefit proposals as required
1712 by section 38C of chapter 3.

1713 (c) The division shall disseminate to health care providers their individualized de-
1714 identified data, including comparisons with other health care providers on the quality, cost and
1715 other data to be published on the consumer health information website.

1716 (d) The division shall coordinate and compile data on quality improvement programs
1717 conducted by state agencies and public and private health care organizations. The division shall

1718 consider programs designed to: (i) improve patient safety in all settings of care; (ii) reduce
1719 preventable hospital readmissions; (iii) prevent the occurrence of and improve the treatment and
1720 coordination of care for chronic diseases; and (iv) reduce variations in care. The division shall
1721 make such information available on the division's consumer health information website. The
1722 division may recommend legislation or regulatory changes as needed to further implement
1723 quality improvement initiatives.

1724 Section 59. (a) The division shall establish and maintain a consumer health information
1725 website. The website shall contain information comparing the quality and cost of health care
1726 services and may also contain general health care information as the division deems appropriate.
1727 The website shall be designed to assist consumers in making informed decisions regarding their
1728 medical care and informed choices among health care providers. Information shall be presented
1729 in a format that is understandable to the average consumer. The division shall take appropriate
1730 action to publicize the availability of its website.

1731 (b) The website shall provide updated information on a regular basis, at least annually,
1732 and additional comparative quality and price information shall be published as determined by the
1733 division. To the extent possible, the website shall include: (i) comparative price information for
1734 the most common referral or prescribed services, as determined by the division, and shall be
1735 listed by facility, provider, provider group practice, accountable care organization, or any other
1736 provider grouping, as determined by the division, provided that such information is categorized
1737 by payor; (ii) comparative quality information, as determined by division, available by facility,
1738 provider, provider group practice, accountable care organization or any other provider grouping,
1739 as determined by the division, for each such service for which comparative price information is
1740 provided; (iii) general information related to each service for which comparative information is

1741 provided; (iv) comparative quality information, as determined by the division, available by
1742 facility, provider, provider group practice or accountable care organization that is not service-
1743 specific, including information related to patient safety and satisfaction; (v) data concerning
1744 healthcare-associated infections and serious reportable events reported under section 51H of
1745 chapter 111; (vi) definitions of common health insurance and medical terms including, but not
1746 limited to those determined under sections 2715(g)(2) and (3) of the Public Service Act, so that
1747 consumers may compare health coverage and understand the terms of their coverage; (vii) a list
1748 of health care provider types, including but not limited to primary care physicians, nurse
1749 practitioners and physician assistants, and what types of services they are authorized to perform
1750 in the commonwealth under state and federal scope of practice laws; (viii) factors consumers
1751 should consider when choosing an insurance product or provider group, including, but not
1752 limited to provider network, premium, cost-sharing, covered services, and tiering; ix) decision
1753 aids for patients to facilitate conversations with their health care providers on key health
1754 decisions; and (x) descriptions of standard quality measures, as determined by the division.

1755 (c) The division shall develop and adopt, on an annual basis, a reporting plan specifying
1756 the quality and cost measures to be included on the consumer health information website and the
1757 security measures used to maintain confidentiality and preserve the integrity of the data. In
1758 developing the reporting plan, the division, to the extent possible, shall collaborate with other
1759 organizations or state or federal agencies that develop, collect and publicly report health care
1760 quality and cost measures and the division shall give priority to those measures that are already
1761 available in the public domain. As part of the reporting plan, the division shall determine for
1762 each service the comparative information to be included on the consumer health information
1763 website.

1764 Section 60. There shall be a task force consisting of 13 members with expertise in
1765 behavioral health treatment, service delivery, integration of behavioral health with primary care,
1766 and behavioral health reimbursement systems. Members shall include one representative from
1767 each of the following organizations representing mental health professionals and clinical,
1768 hospital and consumer advocacy groups: Massachusetts Psychiatric Society, Massachusetts
1769 Psychological Association, National Association of Social Workers- Massachusetts Chapter,
1770 Massachusetts Mental Health Counselors Association, Nurses United for Responsible Services,
1771 Massachusetts Association for Registered Nurses, Massachusetts Association of Behavioral
1772 Health Systems, Association for Behavioral Healthcare, Mental Health Legal Advisors
1773 Committee, National Alliance for the Mentally Ill, Children’s Mental Health Campaign, Home
1774 Care Alliance of Massachusetts and one member chosen by the governor . The task force shall
1775 report to the division its findings and recommendations relative to (a) the most effective and
1776 appropriate approach to including behavioral health services in the array of services provided by
1777 ACOs, including transition planning for providers and maintaining continuity of care; (b) how
1778 current prevailing reimbursement methods and covered behavioral health benefits may need to
1779 be modified to achieve more cost effective, integrated and high quality behavioral health
1780 outcomes including attention to interoperative electronic health records; (c) the extent to which
1781 and how payment for behavioral health services should be included under alternative payment
1782 methodologies established or regulated under this act including how mental health parity and
1783 patient choice of providers and services could be achieved and the design and use of medical
1784 necessity criteria and protocols; (d) how best to educate all providers to recognize behavioral
1785 health conditions and make appropriate decisions regarding referral to behavioral health services;
1786 and (e) the unique privacy factors required for the integration of behavioral health information

1787 into interoperative electronic health records. The first meeting shall be convened within 60 days
1788 after passage of this act. The task force shall submit its report findings and recommendations to
1789 the division no later than February 1, 2013.

1790 Section 61. (a) There shall be in the division a health care workforce center to improve
1791 access to health care services. The center and the commissioner of labor and workforce
1792 development, shall: (i) coordinate the department's health care workforce activities with other
1793 state agencies and public and private entities involved in health care workforce training,
1794 recruitment and retention; (ii) monitor trends in access to primary care providers, nurse
1795 practitioners practicing as primary care providers, and other physician and nursing providers,
1796 through activities including: (1) review of existing data and collection of new data as needed to
1797 assess the capacity of the health care workforce to serve patients, including patient access and
1798 regional disparities in access to physicians or nurses and to examine physician and nursing
1799 satisfaction; (2) review existing laws, regulations, policies, contracting or reimbursement
1800 practices, and other factors that influence recruitment and retention of physicians and nurses; (3)
1801 making projections on the ability of the workforce to meet the needs of patients over time; (4)
1802 identifying strategies currently being employed to address workforce needs, shortages,
1803 recruitment and retention; (5) studying the capacity of public and private medical and nursing
1804 schools in the commonwealth to expand the supply of primary care physicians and nurse
1805 practitioners practicing as primary care providers; (iii) establish criteria to identify underserved
1806 areas in the commonwealth for administering the loan repayment program established under
1807 section 63 and for determining statewide target areas for health care provider placement based on
1808 the level of access; and (iv) address health care workforce shortages through the following
1809 activities, including: (1) coordinating state and federal loan repayment and incentive programs

1810 for health care providers; (2) providing assistance and support to communities, physician groups,
1811 community health centers and community hospitals in developing cost-effective and
1812 comprehensive recruitment initiatives; (3) maximizing all sources of public and private funds for
1813 recruitment initiatives; (4) designing pilot programs and make regulatory and legislative
1814 proposals to address workforce needs, shortages, recruitment and retention; (5) making short-
1815 term and long-term programmatic and policy recommendations to improve workforce
1816 performance, address identified workforce shortages and recruit and retain physicians and
1817 nurses; and (6) administering the health care workforce trust fund as established under section
1818 2CCCC of chapter 29.

1819 (b) The center shall maintain ongoing communication and coordination the health
1820 disparities council, established by section 16O of chapter 6A.

1821 (c) The center shall annually submit a report, not later than March 1, to the governor, the
1822 health disparities council established by section 16O of chapter 6A; and the general court, by
1823 filing the report with the clerk of the house of representatives, the clerk of the senate, the joint
1824 committee on labor and workforce development, the joint committee on health care financing,
1825 and the joint committee on public health. The report shall include: (i) data on patient access and
1826 regional disparities in access to physicians, by specialty and sub-specialty, and nurses; (ii) data
1827 on factors influencing recruitment and retention of physicians and nurses; (iii) short and long-
1828 term projections of physician and nurse supply and demand; (iv) strategies being employed by
1829 the council or other entities to address workforce needs, shortages, recruitment and retention; (v)
1830 recommendations for designing, implementing and improving programs or policies to address
1831 workforce needs, shortages, recruitment and retention; and (vi) proposals for statutory or
1832 regulatory changes to address workforce needs, shortages, recruitment and retention.

1833 Section 62. (a) There shall be a health care workforce loan repayment program,
1834 administered by the health care workforce center established by section 61. The program shall
1835 provide repayment assistance for medical school loans to participants who: (i) are graduates of
1836 medical or nursing schools; (ii) specialize in family health or medicine, internal medicine,
1837 pediatrics, psychiatry, or obstetrics/gynecology; (iii) demonstrate competency in health
1838 information technology at least equivalent to federal meaningful use standards as set forth in 45
1839 C.F.R. Part 170, including use of electronic medical records, computerized physician order entry
1840 and e-prescribing; and (iv) meet other eligibility criteria, including service requirements,
1841 established by the board. Each recipient shall be required to enter into a contract with the
1842 commonwealth which shall obligate the recipient to perform a term of service of no less than 2
1843 years in medically underserved areas as determined by the center.

1844 (b) The center shall promulgate regulations for the administration and enforcement of this
1845 section which shall include penalties and repayment procedures if a participant fails to comply
1846 with the service contract.

1847 The center shall establish criteria to identify medically underserved areas within the
1848 commonwealth. These criteria shall consist of quantifiable measures, which may include the
1849 availability of primary care medical services within reasonable traveling distance, poverty levels,
1850 and disparities in health care access or health outcomes.

1851 Section 63. (a) As used in this section, “primary care provider”, shall mean a health care
1852 professional qualified to provide general medical care for common health care problems who (1)
1853 supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2)

1854 initiates referrals for specialist care; and (3) maintains continuity of care within the scope of
1855 practice.

1856 (b) Pursuant to regulations to be promulgated by the division, there shall be established a
1857 primary care residency grant program for the purpose of financing the training of primary care
1858 providers at teaching community health centers. Eligible applicants shall include teaching
1859 community health centers accredited through affiliations with a Commonwealth funded medical
1860 school or licensed as part of a teaching hospital with a residency program in primary care or
1861 family medicine and teaching health centers that are the independently accredited sponsoring
1862 organization for the residency program and whose residents are employed by the health center.

1863 To receive funding, an applicant shall a) include a review of recent graduates of the
1864 community health center's residency program, including information regarding what type of
1865 practice said graduates are involved in two years following graduation from the residency
1866 program; and b) achieve a threshold of at least 50 percent for the percentage of graduates
1867 practicing primary care within two years after graduation. Graduates practicing a) more than 50
1868 percent inpatient care or b) more than 50 percent specialty care as listed in the American Medical
1869 Association Masterfile shall not qualify as graduates practicing primary care.

1870 Awardees of the primary care residency grant program shall maintain their teaching
1871 accreditation as either an independent teaching community health center or as a teaching
1872 community health center accredited through affiliation with a Commonwealth funded medical
1873 school or licensed as part of a teaching hospital.

1874 The division shall determine via regulation grant amounts per full-time resident. Funds
1875 for such grants shall come from the health care workforce trust fund established under section
1876 2CCCC of chapter 29.

1877 Section 64. Pursuant to regulations to be promulgated by the division, there shall be
1878 established a primary care workforce development and loan forgiveness grant program at
1879 community health centers, for the purpose of enhancing recruitment and retention of primary
1880 care physicians and other clinicians at community health centers throughout the commonwealth.
1881 Such grant program shall be administered by the Massachusetts League of Community Health
1882 Centers in consultation with the director of the health care workforce center and relevant member
1883 agencies. Funds shall be matched by other public and private funds. The League shall work with
1884 said director and said agencies to maximize all sources of public and private funds.

1885 Section 65. (a) There is hereby established within the division an office of patient
1886 protection. The office shall:—

1887 (1) have the authority to administer and enforce the standards and procedures established
1888 by sections 13, 14, 15 and 16 of chapter 176O. The division shall promulgate such regulations to
1889 enforce this section. Such regulations shall protect the confidentiality of any information about a
1890 carrier or utilization review organization, as defined in said chapter 176O, which, in the opinion
1891 of the office, and in consultation with the division of insurance, is proprietary in nature. The
1892 regulations authorized by this section shall be consistent with, and not duplicate or overlap with,
1893 regulations promulgated by the bureau of managed care established in the division of insurance
1894 pursuant to said chapter 176O;

1895 (2) make managed care information collected by the office readily accessible to
1896 consumers on the division of health care cost and quality website. The information shall, at a
1897 minimum, include (i) the health plan report card developed pursuant to section 24 of chapter
1898 118G, (ii) a chart, prepared by the office, comparing the information obtained on premium
1899 revenue expended for health care services as provided pursuant to subsection (3) of paragraph (b)
1900 of section 7 of chapter 176O, for the most recent year for which information is available, and (iii)
1901 data collected pursuant to paragraph (c);

1902 (3) assist consumers with questions or concerns relating to managed care, including but
1903 not limited to exercising the grievance and appeals rights established by sections 13 and 14 of
1904 said chapter 176O;

1905 (4) monitor quality-related health insurance plan information relating to managed care
1906 practices;

1907 (5) regulate the establishment and functions of review panels established by section 14 of
1908 chapter 176O;

1909 (6) periodically advise the division, the commissioner of insurance, the managed care
1910 oversight board established by section 16D of chapter 6A, the joint committee on health care
1911 financing and the joint committee on financial services on actions, including legislation, which
1912 may improve the quality of managed care health insurance plans; and

1913 (7) administer and grant enrollment waivers under paragraph (4) of subsection (a) of
1914 section 4 of chapter 176J; provided, however, that the office of patient protection may grant a
1915 waiver to an eligible individual who certifies, under penalty of perjury, that such individual did
1916 not intentionally forego enrollment into coverage for which the individual is eligible and that is

1917 at least actuarially equivalent to minimum creditable coverage; provided further, that the office
1918 shall establish by regulation standards and procedures for enrollment waivers.

1919 (8) establish by regulation procedures and rules relating to appeals by consumers
1920 aggrieved by restrictions on patient choice, denials of services or quality of care resulting from
1921 any final action of an accountable care organizations, and to conduct hearings and issue rulings
1922 on appeals brought by ACO consumers that are not otherwise properly heard through the
1923 consumer's payer or provider.

1924 (b) The commissioner of insurance shall establish an external review system for the
1925 review of grievances submitted by or on behalf of insureds of carriers pursuant to section 14 of
1926 chapter 176O. The division shall establish an external review process for the review of
1927 grievances submitted by or on behalf of ACO patients and shall specify the maximum amount of
1928 time for the completion of a determination and review after a grievance is submitted. The
1929 division shall establish expedited review procedures applicable to emergency situations, as
1930 defined by regulation promulgated by the division.

1931 (c) Each entity that compiles the health plan employer data and information set, so-
1932 called, for the National Committee on Quality Assurance, or collects other information deemed
1933 by the entity as similar or equivalent thereto, shall, upon submitting said data and information
1934 sent to the division of health care cost and quality pursuant to section 24 of chapter 118G,
1935 concurrently submit to the office of patient protection a copy thereof excluding, at the entity's
1936 option, proprietary financial data.

1937 Section 66. (a) All expenses incurred in carrying out this chapter shall be payable solely
1938 from funds provided under the authority of this chapter and no liability or obligations shall be

1939 incurred by the division hereunder beyond the extent to which monies shall have been provided
1940 under this chapter.

1941 (b) The division shall be liable on all claims made as a result of the activities, whether
1942 ministerial or discretionary, of any member, officer, or employee of the division acting as such,
1943 except for willful dishonesty or intentional violation of the law, in the same manner and to the
1944 same extent as a private person under like circumstances; provided, however, that the division
1945 shall not be liable to levy or execution on any real or personal property to satisfy judgment, for
1946 interest prior to judgment, for punitive damages or for any amount in excess of \$100,000.

1947 (c) No person shall be liable to the commonwealth, to the division or to any other person
1948 as a result of his activities, whether ministerial or discretionary, as a member, officer or
1949 employee of the division except for willful dishonesty or intentional violation of the law;
1950 provided, however, that such person shall provide reasonable cooperation to the division in the
1951 defense of any claim. Failure of such person to provide reasonable cooperation shall cause him to
1952 be jointly liable with the division, to the extent that such failure prejudiced the defense of the
1953 action.

1954 (d) The division may indemnify or reimburse any person, or his personal representative,
1955 for losses or expenses, including legal fees and costs, arising from any claim, action, proceeding,
1956 award, compromise, settlement or judgment resulting from such person's activities, whether
1957 ministerial or discretionary, as a member, officer or employee of the division; provided that the
1958 defense of settlement thereof shall have been made by counsel approved by the division. The
1959 division may procure insurance for itself and for its members, officers and employees against
1960 liabilities, losses and expenses which may be incurred by virtue of this section or otherwise.

1961 (e) No civil action hereunder shall be brought more than 3 years after the date upon
1962 which the cause thereof accrued.

1963 (f) Upon dissolution, liquidation or other termination of the division, all rights and
1964 properties of the division shall pass to and be vested in the commonwealth, subject to the rights
1965 of lien holders and other creditors. In addition, any net earnings of the division, beyond that
1966 necessary for retirement of any indebtedness or to implement the public purpose or purposes or
1967 program of the commonwealth, shall not inure to the benefit of any person other than the
1968 commonwealth.

1969 Section 67. The division shall keep an accurate account of all its activities and of all its
1970 receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year
1971 to its board, to the governor, to the general court, and to the state auditor, such reports to be in a
1972 form prescribed by the board, with the written approval of the auditor. The auditor may
1973 investigate the affairs of the division, may severally examine the properties and records of the
1974 division, and may prescribe methods of accounting and the rendering of periodic reports in
1975 relation to projects undertaken by the division. The division shall be subject to biennial audit by
1976 the state auditor.

1977 Section 68. The division shall develop the uniform reporting of a standard set of health
1978 care quality measures for each health care provider facility, medical group, or provider group in
1979 the commonwealth hereinafter referred to as the "Standard Quality Measure Set."

1980 The division shall convene a statewide advisory committee which shall recommend to the
1981 division a Standard Quality Measure Set. The statewide advisory committee shall consist of the
1982 executive director of the division or designee, who shall serve as the chair; the executive director

1983 of the group insurance commission or designee, the Medicaid director designee; and 6
1984 representatives of organizations to be appointed by the governor including at least 1
1985 representative from an acute care hospital or hospital association, 1 representative from a
1986 provider group or medical association or provider association, 1 representative from a medical
1987 group, 1 representative from a private health plan or health plan association, 1 representative
1988 from an employer association and 1 representative from a health care consumer group.

1989 In developing its recommendation of the Standard Quality Measure Set, the advisory
1990 committee shall, after consulting with state and national organizations that monitor and develop
1991 quality and safety measures, select from existing quality measures and shall not select quality
1992 measures that are still in development or develop its own quality measures. The committee shall
1993 annually recommend to the division any updates to the Standard Quality Measure Set by
1994 November 1. For its recommendation beginning in 2012, the committee may solicit for
1995 consideration and recommend other nationally recognized quality measures not yet developed or
1996 in use as of November 1, 2010, including recommendations from medical or provider specialty
1997 groups as to appropriate quality measures for that group's specialty. At a minimum, the Standard
1998 Quality Measure Set shall consist of the following quality measures: (i) the Centers for Medicare
1999 and Medicaid Services hospital process measures for acute myocardial infarction, congestive
2000 heart failure, pneumonia and surgical infection prevention; (ii) the Hospital Consumer
2001 Assessment of Healthcare Providers and Systems survey; (iii) the Healthcare Effectiveness Data
2002 and Information Set reported as individual measures and as a weighted aggregate of the
2003 individual measures by medical or provider group; and (iv) the Ambulatory Care Experiences
2004 Survey.

2005 The division shall require all payers to limit their collection and utilization of health care
2006 quality measures from providers to the standard quality measure set, as developed by the division
2007 under this section.

2008 Section 69. (a) Acute hospitals, as defined in section 34, ambulatory surgical centers, as
2009 defined in 34, accountable care organizations, as defined in section 1, and physician
2010 organizations, as defined in section 53H of chapter 111, shall pay for the estimated expenses of
2011 the division and health safety net office. The amount to be paid for such expenses shall be equal
2012 to the net amount, as defined in subsection (g). Acute hospitals, ambulatory surgical centers,
2013 accountable care organizations and physician organizations shall assess an administrative
2014 surcharge on all payments subject to administrative surcharge as defined in subsection (g). The
2015 administrative surcharge shall be distinct from any other amount paid by an administrative
2016 surcharge payer, as defined in subsection (g), for the services of an acute hospital, ambulatory
2017 surgical center, accountable care organization or physician organization and shall be in addition
2018 to the surcharge imposed under section 38. The administrative surcharge amount shall equal the
2019 product of (i) the administrative surcharge percentage and (ii) amounts paid for these services by
2020 an administrative surcharge payer. The division shall calculate the administrative surcharge
2021 percentage by dividing the net amount, as defined in this section, by the projected annual
2022 aggregate payments subject to the administrative surcharge, excluding projected annual
2023 aggregate payments based on payments made by managed care organizations. The division shall
2024 subsequently adjust the administrative surcharge percentage for any variation in the net amount.
2025 The division shall determine the administrative surcharge percentage before the start of each
2026 fiscal year and may recalculate the surcharge percentage before April 1 of each fiscal year if the
2027 office projects that the initial administrative surcharge percentage established the previous

2028 October will produce less or more than the net amount in administrative surcharge payments,
2029 excluding payments made by managed care organizations, as defined in section 34. Before each
2030 succeeding October 1, the division shall recalculate the administrative surcharge percentage
2031 incorporating any adjustments from earlier years. In each calculation or recalculation of the
2032 administrative surcharge percentage, the division shall use the best data available as determined
2033 by the division and may consider the effect on projected administrative surcharge payments of
2034 any modified or waived enforcement pursuant to subsection (e). The division shall incorporate
2035 all adjustments, including, but not limited to, updates or corrections or final settlement amounts,
2036 by prospective adjustment rather than by retrospective payments or assessments. In the event of
2037 late payment by an administrative surcharge payer, the treasurer shall advance the amount of due
2038 and unpaid funds to the division prior to the receipt of such monies in anticipation of such
2039 revenues up to the amount authorized in the then current budget attributable to the administrative
2040 surcharge, and the division shall reimburse the treasurer for such advances upon receipt of such
2041 revenues. The provisions of this paragraph shall not apply to any state institution or to any acute
2042 hospital which is operated by a city or town.

2043 (b) Each acute hospital, ambulatory surgical center, accountable care organization and
2044 physician organization shall bill an administrative surcharge payer an amount equal to the
2045 administrative surcharge described in this section as a separate and identifiable amount distinct
2046 from any amount paid by an administrative surcharge payer for acute hospital, ambulatory
2047 surgical center, ACO or physician organization services, and as a separate and identifiable
2048 amount distinct from any surcharge paid under section 38. Each administrative surcharge payer
2049 shall pay the administrative surcharge amount to the division. Each administrative surcharge
2050 payer shall make a preliminary payment to the division on October first of each year in an

2051 amount equal to one-half of the previous year's administrative surcharge amount. Thereafter,
2052 each administrative surcharge payer shall pay, within 30 days of the date of notice from the
2053 division, the balance of the total administrative surcharge amount for the current year. Upon the
2054 written request of an administrative surcharge payer, the division may implement another billing
2055 or collection method for the surcharge payer; provided, however, that the division has received
2056 all information that it requests which is necessary to implement such billing or collection
2057 method; and provided further, that the division shall specify by regulation the criteria for
2058 reviewing and approving such requests and the elements of such alternative method or methods.

2059 (c) The division shall specify by regulation appropriate mechanisms that provide for
2060 determination and payment of an administrative surcharge payer's liability, including
2061 requirements for data to be submitted by administrative surcharge payers, ambulatory surgical
2062 center, acute hospitals, ACOs and physician organizations.

2063 (d) An administrative surcharge payer's liability to the commonwealth shall in the case of
2064 a transfer of ownership be assumed by the successor in interest to the administrative surcharge
2065 payer.

2066 (e) The division shall establish by regulation an appropriate mechanism for enforcing an
2067 administrative surcharge payer's liability to the division if an administrative surcharge payer
2068 does not make a scheduled payment to the fund; provided, however, that the division may, for
2069 the purpose of administrative simplicity, establish threshold liability amounts below which
2070 enforcement may be modified or waived. Such enforcement mechanism may include assessment
2071 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent
2072 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement

2073 mechanism may also include notification to the office of Medicaid requiring an offset of
2074 payments on the claims of the administrative surcharge payer, any entity under common
2075 ownership or any successor in interest to the administrative surcharge payer, from the office of
2076 Medicaid in the amount of payment owed to the commonwealth including any interest and
2077 penalties, and to transfer the withheld funds to the commonwealth. If the office of Medicaid
2078 offsets claims payments as ordered by the division, the office of Medicaid shall be considered
2079 not to be in breach of contract or any other obligation for payment of non-contracted services,
2080 and an administrative surcharge payer whose payment is offset under an order of the division
2081 shall serve all Title XIX recipients under the contract then in effect with the executive office of
2082 health and human services. In no event shall the division direct the office of Medicaid to offset
2083 claims unless the administrative surcharge payer has maintained an outstanding liability to the
2084 fund for a period longer than 45 days and has received proper notice that the division intends to
2085 initiate enforcement actions under regulations promulgated by the division.

2086 (f) If an administrative surcharge payer, ambulatory surgical center, acute hospital,
2087 accountable care organization or physician organization fails to file any data, statistics or
2088 schedules or other information required under subsection (c) or by any regulation promulgated
2089 by the division in connection with the administrative surcharge, the division shall provide written
2090 notice to the administrative surcharge payer, ambulatory surgical center, acute hospital,
2091 accountable care organization or physician organization, as the case may be. If an administrative
2092 surcharge payer, ambulatory surgical center, acute hospital, accountable care organization or
2093 physician organization fails to provide required information within 14 days after the receipt of
2094 written notice, or falsifies the same, he shall be subject to a civil penalty of not more than \$5,000
2095 for each day on which the violation occurs or continues, which penalty may be assessed in an

2096 action brought on behalf of the commonwealth in any court of competent jurisdiction. The
2097 attorney general shall bring any appropriate action, including injunctive relief, necessary for the
2098 enforcement of this chapter.

2099 (g) As used in this section, the following words the following words shall, unless the
2100 context clearly requires otherwise, have the following meanings:-

2101 "Administrative surcharge payer", an individual or entity that pays for or arranges for the
2102 purchase of health care services provided by acute hospitals, ambulatory surgical centers,
2103 accountable care organizations or physician organizations, as defined in this chapter; provided,
2104 however, that the term "administrative surcharge payer" shall include a managed care
2105 organization; and provided further, that "administrative surcharge payer" shall not include Title
2106 XVIII and Title XIX programs and their beneficiaries or recipients, other governmental
2107 programs of public assistance and their beneficiaries or recipients and the workers' compensation
2108 program established under chapter 152.

2109 "Net amount" shall mean the amount established for the estimated annual expenses of the
2110 division of health care cost and quality, established by section 2 and the health safety net office,
2111 established by section 35. This amount shall be equal to the amount appropriated by the general
2112 court for the expenses of the division of health care cost and quality and the health safety net
2113 office minus amounts collected from (1) filing fees, (2) fees and charges generated by the
2114 division's publication or dissemination of reports and information, (3) federal matching revenues
2115 received for these expenses or received retroactively for expenses of predecessor agencies.
2116 Estimated and actual expenses of the division and the office shall include an amount equal to the

2117 cost of fringe benefits, as established by the division of administration pursuant to section 6B of
2118 chapter 29

2119 “Payments subject to administrative surcharge”, shall mean all amounts paid, directly or
2120 indirectly, by administrative surcharge payers to acute hospitals, ambulatory surgical centers,
2121 accountable care organizations and physician organizations for health services; provided,
2122 however, that “payments subject to administrative surcharge” shall not include: (i) payments,
2123 settlements and judgments arising out of third party liability claims for bodily injury which are
2124 paid under the terms of property or casualty insurance policies; (ii) payments made on behalf of
2125 Medicaid recipients, Medicare beneficiaries or persons enrolled in policies issued under chapter
2126 176K or similar policies issued on a group basis; provided further, that “payments subject to
2127 administrative surcharge” shall include payments made by a managed care organization on
2128 behalf of: (i) Medicaid recipients under age 65; and (ii) enrollees in the commonwealth care
2129 health insurance program; and provided further, that “payments subject to administrative
2130 surcharge” may exclude amounts established under regulations promulgated by the division for
2131 which the costs and efficiency of billing an administrative surcharge payer or enforcing
2132 collection of the surcharge from an administrative surcharge payer would not be cost effective.

2133 Section 70. Every health care provider, as defined in section 1 of chapter 118G, shall
2134 track and report quality information at least annually under regulations promulgated by the
2135 department. The division shall disclose quality information collected under this section and
2136 section 51H of chapter 111 to providers defined by said division.

2137 SECTION 48. Chapter 118H of the General Laws is hereby amended by inserting after
2138 section 6 the following section:-

2139 Section 7. The commonwealth care health insurance program shall attribute every
2140 member to a primary care provider.

2141 SECTION 49. Section 25B of chapter 111, as so appearing, is hereby amended, in line
2142 24, by striking out the figure “\$7,500,000” and inserting in place thereof the following figure:-
2143 “\$10,000,000”.

2144 SECTION 50. Section 25B of chapter 111, as so appearing, is hereby amended, in line
2145 35, by inserting the word “has” the following word:- “been”.

2146 SECTION 51. Section 25B of chapter 111, as so appearing, is hereby amended, in line
2147 43, by striking out the figure “\$25,000,000” and inserting in place thereof the following figure:-
2148 “\$10,000,000”

2149 SECTION 52. Section 25B of chapter 111, as so appearing, is hereby amended, in line
2150 47 and 48, by striking out the phrase “, institution for the care of unwed mothers”.

2151 SECTION 53. Section 25B of chapter 111, as so appearing, is hereby amended, in line
2152 49, by striking out the phrase “, which is an infirmary maintained in a town”.

2153 SECTION 54. Section 25B of chapter 111, as so appearing, is hereby amended, in line
2154 54, by striking out the phrase “mentally ill or retarded” and inserting in place thereof the
2155 following:- “developmentally disabled or mentally ill”.

2156 SECTION 55. Section 25B of chapter 111, as so appearing, is hereby amended, in line
2157 85, by inserting after the word “basis” the following phrase:- “whether provided in a free
2158 standing ambulatory surgical center licensed as a clinic pursuant to section 51 or by a hospital.

2159 SECTION 56. Section 25B of chapter 111 is hereby amended by striking out the
2160 definition “Innovative service” and inserting in place thereof the following definition:-

2161 “Innovative service”, a service or procedure, which for reasons of quality, access, or cost
2162 is determined to be innovative by the department.

2163 SECTION 57. Section 25B of chapter 111 is hereby amended by striking out the
2164 definition “New technology” and inserting in place thereof the following definition:-

2165 “New technology”, equipment such as magnetic resonance imagers, and linear
2166 accelerators or interventional radiology units as defined by the department, or a service, as
2167 defined by the department, which for reasons of quality, access or cost is determined to be new
2168 technology by the department.

2169 SECTION 58. Section 25B of chapter 111, as appearing, is hereby amended, in lines
2170 120-121, the words “A new technology or innovate” and inserting in place thereof the following
2171 words:- “a new technology or innovative”

2172 SECTION 59. Section 25B of chapter 111, as appearing, is hereby amended, in line 122,
2173 after parenthesis (b) the following new words:- “for any acute hospital, any increase in bed
2174 capacity of more than 4 beds, (c)”

2175 SECTION 60. Section 25B of chapter 111, as so appearing, is amended by striking out,
2176 in lines 149-154, the last sentence of the definition of “Substantial change in services” and
2177 inserting in place thereof the following sentence:- Notwithstanding any other provisions to the
2178 contrary, the department may further define what constitutes a substantial change in service in

2179 regulations, including, but not limited to, any changes in its provision of ambulatory surgery
2180 services by any facility that provides ambulatory surgery.

2181 SECTION 61. Section 25C of chapter 111, as so appearing, is amended by striking out,
2182 in lines 4 and 5, the words “or substantially change the service of such facility” and inserting in
2183 place thereof the following words:- “, substantially change the service of such facility, or transfer
2184 ownership of a facility that requires a determination of need as a condition of initial licensure.

2185 SECTION 62. Section 25C of chapter 111, as so appearing, is hereby amended by
2186 striking out, in lines 42 – 44, the words “, in any location other than a health care facility, as such
2187 term is defined in section twenty-five B” and inserting in place thereof the following words:- “or
2188 as determined by the department”.

2189 SECTION 63. Section 25C of chapter 111, as so appearing, is hereby amended by
2190 striking out, in line 62, the words “magnetic resonance imaging equipment” and inserting in
2191 place thereof the following words:- “new technology”

2192 SECTION 64. Section 25C of chapter 111, as so appearing, is hereby further amended
2193 by striking out the fourth paragraph and inserting in place thereof the following paragraph:-“No
2194 person or agency of the commonwealth or any political subdivision thereof shall acquire for
2195 location in other than a health care facility a unit of medical, diagnostic, or therapeutic
2196 equipment, other than equipment used to provide an innovative service or which is a new
2197 technology, as such terms are defined in section 25B, with a fair market value in excess of
2198 \$150,000 unless the person or agency notifies the department of the person’s or agency’s intent
2199 to acquire such equipment and of the use that will be made of the equipment. Such notice shall
2200 be made in writing and shall be received by the department at least 30 days before contractual

2201 arrangements are entered into to acquire the equipment with respect to which notice is given. A
2202 determination by the department of need therefor shall be required for any such acquisition (i) if
2203 the notice required by this paragraph is not filed in accordance with the requirements of this
2204 paragraph, and (ii) if the requirements for exemption under subsection (a) of section twenty-five
2205 C1/2; provided, however, that in no event shall any person who acquires a unit of new
2206 technology for location other than in a health care facility refer or influence any referrals of
2207 patients to said equipment, unless said person is a physician directly providing services with that
2208 equipment; provided, however, that for the purposes of this section, no public advertisement
2209 shall be deemed a referral or an influence of referrals; and provided, further, that any person who
2210 has an ownership interest in said equipment, whether direct or indirect, shall disclose said
2211 interest to patients utilizing said equipment in a conspicuous manner. “.

2212 SECTION 65. Section 25C of chapter 111, as so appearing, is hereby further amended
2213 by striking out paragraphs 5 through 7 inclusive, and inserting in place thereof the following 3
2214 paragraphs:—

2215 A determination of need shall be required for acquisition of a hospital by any person,
2216 agency of the commonwealth or political subdivision thereof. In making any such
2217 determination, the department may consider the financial capacity of the prospective licensee to
2218 operate the hospital in accordance with applicable laws, whether the transaction will create a
2219 significant effect on the availability or accessibility of health care services to the affected
2220 communities, the ability of the prospective owner to meet the additional requirements for
2221 licensure under section 51G as determined by the department, and the applicant’s plan for the
2222 provision of community benefits, including the identification and provision of essential health
2223 services.

2224 The department, in making any determination of need, shall encourage appropriate
2225 allocation of private and public health care resources and the development of alternative or
2226 substitute methods of delivering health care services so that adequate health care services will be
2227 made reasonably available to every person within the commonwealth at the lowest reasonable
2228 aggregate cost, may impose terms and conditions as the department reasonably determines are
2229 necessary to achieve the purposes and intent of this section, including but not limited to
2230 maintenance of existing, or addition of new, services and may consider additional factors. The
2231 department may also recognize the special needs and circumstances of projects that (1) are
2232 essential to the conduct of research in basic biomedical or health care delivery areas or to the
2233 training of health care personnel, (2) are unlikely to result in any increase in the clinical bed
2234 capacity or outpatient load capacity of the facility, and (3) are unlikely to cause an increase in the
2235 total patient care charges of the facility to the public for health care services, supplies, and
2236 accommodations, as such charges shall be defined from time to time in accordance with section 5
2237 of chapter 409 of the acts of 1976. Any determination of need shall be guided by the state health
2238 plan.

2239 Applications for such determination shall be filed with the department, together with such
2240 other forms and information as shall be prescribed by, or acceptable to, the department. A
2241 duplicate copy of any application together with supporting documentation therefor, shall be a
2242 public record and kept on file in the department. The department may require a public hearing on
2243 any application. A reasonable fee, established by the department, shall be paid upon the filing of
2244 such application; provided, that in no event shall such fee exceed one-fifth of one per cent of the
2245 capital expenditures, if any, proposed by the applicant or 0.2 per cent of the acquisition costs of a
2246 transfer of ownership.

2247 SECTION 66. Said chapter 111, as so appearing, is hereby further amended by inserting
2248 after section 25E the following section:—

2249 Section 25E½. (a) There shall be in the department a division of health planning, in this
2250 section called the division. The division shall develop a state health plan, and may amend the
2251 plan as necessary.

2252 (b) There shall be in the department a health planning council consisting of the
2253 commissioner or designee, the director of the office of Medicaid or designee, the executive
2254 director of the division of health care cost and quality or designee, the secretary of health and
2255 human services or designee, the director of the division, and 3 members appointed by the
2256 governor, of whom at least 1 shall be a health economist; at least 1 shall have experience in
2257 health policy and planning, and at least 1 shall have experience in health care market planning
2258 and service line analysis. The health planning council shall advise the division and shall oversee
2259 and issue the state health plan developed by the division.

2260 (c) The state health plan developed by the division shall include at least the following: (1)
2261 an inventory of current health care facilities that includes licensed beds, surgical capacity,
2262 numbers of technologies or equipment defined as innovative services or new technologies by the
2263 department, and all other services or supplies that are subject to determination of need, and (2) an
2264 assessment of the need for every such service or supply on a state-wide or regional basis
2265 including projections for such need for at least 5 years.

2266 (d) The department shall issue guidelines, rules, or regulations consistent with the state
2267 health plan for making determinations of need.

2268 SECTION 67. Section 25G of said chapter, as so appearing, is hereby amended by
2269 inserting at the end thereof the following sentence:—

2270 Any violation of such provisions also shall constitute grounds to refuse to accept, review
2271 or consider an application for a determination of need by the facility, its affiliates, including a
2272 parent, subsidiary umbrella organization or another facility in the same health system or
2273 organization; or grounds for additional terms and conditions on any subsequent application for a
2274 determination of need by the facility or its affiliates, including a parent, subsidiary, umbrella
2275 organization or another facility in the same health system or organization for a minimum of 5
2276 years.

2277 SECTION 68. Section 51G of chapter 111, as so appearing, is hereby amended, in line
2278 38, after the words “or services,” the following words:- “conduct a public hearing on the closure
2279 of said essential services or of the hospital. The department shall”.

2280 SECTION 69. Section 51G of chapter 111, as so appearing, is hereby amended, in line
2281 40, by striking out the word “area,” and inserting in place thereof the following words:- “area
2282 and shall”.

2283 SECTION 70. Section 51G of chapter 111, as so appearing, is hereby amended, in line
2284 41, by striking out the words “, and” and inserting in place thereof the following words:- “. In
2285 order to”.

2286 SECTION 71. Section 51G of chapter 111, as so appearing, is hereby amended, in line
2287 44, by inserting after the word “services” the following words:- “, the department shall require
2288 the hospital to continue providing the essential service unless the department finds that such
2289 continuation would impose an undue financial burden on the hospital”.

2290 SECTION 72. Section 51G of chapter 111, as so appearing, is hereby amend by inserting
2291 after paragraph (6) the following paragraph:-(7) Any violation of the requirements under this
2292 section also shall constitute grounds for refusing to grant or renew, modifying or revoking the
2293 license of a health care facility or of any part thereof; grounds to refuse to accept, review or
2294 consider an application for a determination of need by the facility, its affiliates, including a
2295 parent, subsidiary umbrella organization or another facility in the same health system or
2296 organization, or grounds for additional terms and conditions on any subsequent application for a
2297 determination of need by the facility or its affiliates, including a parent, subsidiary, umbrella
2298 organization or another facility in the same health system or organization for a minimum of five
2299 years.

2300 SECTION 73. The General Laws are hereby amended by inserting after chapter 118H
2301 the following chapter:—

2302 CHAPTER 118I. HEALTH INFORMATION TECHNOLOGY

2303 Section 1. As used in this chapter, the following words shall, unless the context clearly
2304 requires otherwise, have the following meanings:—

2305 “Division”, the division of health care cost and quality established under chapter 118G.

2306 “Electronic health record,” a longitudinal electronic record of patient health information
2307 generated by one or more encounters in any care delivery setting.

2308 “Electronic medical home,” the location of a patient’s electronic health record whether
2309 located, maintained or stored on a provider server, at a central storage repository, cloud storage,
2310 or any other storage and retrieval method or location.

2311 “Health information exchange,” an electronic platform enabling the transmission of
2312 healthcare-related data among providers, health care facilities, health information organizations
2313 and government agencies according to national standards, the reliable and secure transfer of data
2314 among diverse systems and access to and retrieval of data.

2315 Section 2. (a) There shall be established a health information technology council within
2316 the division. The council shall advise the division on the dissemination of health information
2317 technology across the commonwealth, including the deployment of electronic health records
2318 systems in all health care provider settings that are networked through a statewide health
2319 information exchange.

2320 (b) The council shall consist of 19 members, as follows: 1 shall be the executive director
2321 of the division, who shall serve as the chair; 1 shall be the secretary of health and human
2322 services; 1 shall be the secretary of administration and finance or designee; 1 shall be the
2323 secretary of housing and economic development or designee; 1 shall be the director of the office
2324 of Medicaid or designee; 1 shall be the commissioner of public health or designee; and 13 shall
2325 be appointed by the governor, of whom at least 1 shall be an expert in health information
2326 technology, 1 shall be an expert in law and health policy, and 1 shall be an expert in health
2327 information privacy and security; 1 shall be from an academic medical center; 1 shall be from a
2328 community hospital; 1 shall be from a community health center; 1 shall be from a long term care
2329 facility; 1 shall be from large physician group practice; 1 shall be from a small physician group
2330 practice; 1 shall represent health insurance carriers; and 3 additional members shall have
2331 experience or expertise in health information technology. The council may consult with parties,
2332 public or private, that it considers desirable in exercising its duties under this section, including
2333 persons with expertise and experience in the development and dissemination of electronic health

2334 records systems, and the implementation of electronic health record systems by small physician
2335 groups or ambulatory care providers, as well as persons representing organizations within the
2336 commonwealth interested in and affected by the development of networks and electronic health
2337 records systems, including, but not limited to, persons representing local public health agencies,
2338 licensed hospitals and other licensed facilities and providers, private purchasers, the medical and
2339 nursing professions, physicians and health insurers, the state quality improvement organization,
2340 academic and research institutions, consumer advisory organizations with expertise in health
2341 information technology and other stakeholders as identified by the secretary of health and human
2342 services. Appointive members of the council shall serve for terms of 2 years or until a successor
2343 is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

2344 Chapter 268A shall apply to all council members, except that the council may purchase
2345 from, sell to, borrow from, contract with or otherwise deal with any organization in which any
2346 council member is in anyway interested or involved; provided, however, that such interest or
2347 involvement shall be disclosed in advance to the council and recorded in the minutes of the
2348 proceedings of the council; and provided further, that no member shall be deemed to have
2349 violated section 4 of said chapter 268A because of his receipt of his usual and regular
2350 compensation from his employer during the time in which the member participates in the
2351 activities of the council.

2352 Section 3. (a) There shall be established within the division a department of health
2353 information technology. The executive director of the division shall appoint a qualified
2354 individual to serve as the director of the department, who shall be an employee of the division,
2355 report to the executive director and manage the affairs of the department. The department shall
2356 advance the dissemination of health information technology across the commonwealth, including

2357 the deployment of electronic health records systems in all health care provider settings that are
2358 networked through a statewide health information exchange.

2359 (b) The department shall have full authority to conduct procurements and enter into
2360 contracts for the purchase and development of any and all hardware or software in connection
2361 with carrying out the purposes of this act. The department shall have the full and exclusive
2362 authority over the technical aspects of the development, dissemination and implementation of
2363 health information technology in the commonwealth including the deployment of electronic
2364 health records systems in all provider settings that are networked through a fully interoperable
2365 statewide health information exchange; provided, however, that the division shall have the sole
2366 responsibility for determining any policy objectives of the health information exchange and other
2367 health information technology.

2368 Section 4. (a) The department, in consultation with the council, shall advance the
2369 dissemination of health information technology by: (i) ensuring the implementation and use of
2370 electronic health records systems by health care providers in order to improve health care
2371 delivery and coordination, reduce unwarranted treatment variation, eliminate wasteful paper-
2372 based processes, help facilitate chronic disease management initiatives and establish
2373 transparency; (ii) ensuring the creation and maintenance of a statewide interoperable electronic
2374 health information exchange that allows individual health care providers in all health care
2375 settings to exchange patient health information with other providers; and (iii) identifying and
2376 promoting an accelerated dissemination in the commonwealth of emerging health care
2377 technologies that have been developed and employed and that are expected to improve health
2378 care quality and lower health care costs, but that have not been widely implemented in the
2379 commonwealth.

2380 (b) In carrying out the purposes of this section, the department shall consult with various
2381 organizations of regional payers and providers involved in the development of a health
2382 information exchange in developing the statewide electronic records plan and annual updates and
2383 in designing, developing, disseminating and implementing health information technology.

2384 Section 5. (a) The director of the department shall prepare and annually update a
2385 statewide electronic health records and health information exchange implementation plan and an
2386 annual update thereto. Each plan shall contain a budget for the application of funds from the
2387 Massachusetts Health Information Technology Fund for use in implementing each such plan.
2388 The director shall submit such plans and updates, and associated budgets, to the division for its
2389 approval. Each such plan and the associated budget shall be subject to approval of the division.

2390 (b) Components of each such plan, as updated, shall be community-based implementation
2391 plans that assess a municipality's or region's readiness to implement and use electronic health
2392 record systems and an interoperable electronic health information exchange within the referral
2393 market for a defined patient population. Each such implementation plan shall address the
2394 development, implementation and dissemination of electronic health records systems among
2395 health care providers in the community or region, particularly providers, such as community
2396 health centers that serve underserved populations, including, but not limited to, racial, ethnic and
2397 linguistic minorities, uninsured persons, and areas with a high proportion of public payer care.

2398 (c) Each plan as updated shall: (i) allow seamless, secure electronic exchange of health
2399 information among health care providers, health plans and other authorized users; (ii) provide
2400 consumers with secure, electronic access to their own health information; (iii) meet all applicable
2401 federal and state privacy and security requirements, including requirements imposed by the

2402 Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American
2403 Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R.
2404 §§160, 162, 164 and 170.; (iv) meet standards for interoperability adopted by the division; (v)
2405 give patients the option of allowing only designated health care providers to disseminate their
2406 individually identifiable information; (vi) provide public health reporting capability as required
2407 under state law; and (vii) allow reporting of health information other than identifiable patient
2408 health information for purposes of such activities as the executive director of the division may
2409 from time to time consider necessary.

2410 (d) Each plan as updated shall be consistent with the mandatory compliance date set forth
2411 in section 9 for implementation of the health information exchange and all other requirements of
2412 this act.

2413 Section 6. The department shall: (i) contract with implementing organizations to
2414 facilitate a public-private partnership that includes representation from hospitals, physicians and
2415 other health care professionals, health insurers, employers and other health care purchasers,
2416 health data and service organizations, and consumer organizations and provide resources and
2417 support to recipients of grants awarded under section 15 to implement each program within the
2418 designated community pursuant to the implementation plan; (ii) certify and disburse funds to
2419 subcontractors, when necessary; (iii) provide technical assistance to facilitate successful practice,
2420 redesign, adoption of electronic health records, and utilization of care management strategies;
2421 (iv) ensure that electronic health records systems are fully interoperable and secure and that
2422 sensitive patient information is kept confidential by exclusively utilizing electronic health
2423 records products that are certified by the Certification Commission for Healthcare Information
2424 Technology; and (v) certify a group of subcontractors who shall provide the necessary hardware

2425 and software for system implementation. Before the department issues requests for proposals for
2426 contracts to be entered into pursuant to this section, the department's director shall consult with
2427 the council and the division with respect to the content of all such proposals. All contracts with
2428 implementing organizations entered into by the department must first be approved by the
2429 division.

2430 Section 7. Every patient shall have full and unrestricted access to his electronic health
2431 record at all times. The department shall develop and implement a method of providing each
2432 patient secure access to such patient's electronic health record. Such methods may include, but
2433 are not limited to, assigning patient personal identification number and protected password
2434 access to their electronic health record, electronic access devices or cards and such other means
2435 as the department may determine.

2436 Section 8. Not later than January 1, 2017, the department shall complete the
2437 development and implementation of a method of health information data storage that will allow
2438 patients and providers the ability to access electronic health records and securely and accurately
2439 exchange electronic health record information as provided in this chapter. Such methods may
2440 include a central storage repository, cloud storage, storage on provider servers, a central
2441 information index and request router, or such other methods as the department shall determine;
2442 provided that any such means of storage and access developed by the department shall be fully
2443 secure and shall ensure compliance with all state and federal privacy requirements, including
2444 those imposed by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191,
2445 the American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and
2446 45 C.F.R. §§160, 162 and 164.

2447 Section 9. (a) The department shall develop and implement no later than January 1,
2448 2017, a fully interoperable information technology platform to support and enable a fully
2449 functional state wide health information exchange that secures the participation of all health care
2450 providers in the exchange. To ensure compliance, the division shall have the authority to impose
2451 penalties as provided in this section.

2452 (b) At a minimum, the health information exchange must enable the following
2453 capabilities:

2454 (i) The storage and maintenance of all electronic health records of a patient at the
2455 patient's electronic medical home;

2456 (ii) Allow providers to contemporaneously and securely transfer information and
2457 records regarding any medical event or encounter to the patient's electronic medical home;

2458 (iii) Allow providers to promptly and securely access and retrieve a patient's
2459 electronic medical record; and

2460 (iv) Allow patients access to their own medical record at all times.

2461 (b) The division is authorized to impose penalties for non-compliance by healthcare
2462 providers with the requirements of this section of up to \$1 per day per member up to a maximum
2463 of 45 days; provided, however, that the division may waive penalties for good cause shown,
2464 including lack of broadband internet access as provided in section 10. Penalties collected under
2465 this section shall be deposited into the wellness and prevention trust fund, as created in section
2466 75 of chapter 10.

2467 Section 10. If a provider is located in a geographic area of the commonwealth that does
2468 not have broadband internet access and, due to lack of such broadband internet access, such
2469 provider is unable to fully comply with the requirements of the health information exchange and
2470 any other health information technology requirements implemented by the department under this
2471 chapter, such provider may apply to the department for a temporary waiver as to any specific
2472 requirement with which it is unable to comply for such reason. If the department determines that
2473 the provider is unable to comply with a requirement due to the lack of broadband internet access,
2474 the division may grant a waiver of such requirement; provided, however, that, upon a
2475 determination by the division that broadband internet access has become available to such
2476 provider since the date of the grant of the waiver, the division shall notify such provider thereof.
2477 Within 180 days of such notice, such provider shall take such actions as are necessary to bring
2478 the provider into full compliance with the requirements of the health information exchange and
2479 any other health information technology requirements implemented by the division under this
2480 chapter.

2481 Section 11. There shall be established and set up on the books of the division the
2482 Massachusetts Health Information Technology Fund, hereinafter referred to as the fund, for the
2483 purpose of supporting the advancement of health information technology in the commonwealth,
2484 including, but not limited to, the full deployment of electronic health records. There shall be
2485 credited to the fund any appropriations, proceeds of any bonds or notes of the commonwealth
2486 issued for the purpose, or other monies authorized by the general court and designated thereto;
2487 any federal grants or loans; any private gifts, grants or donations made available; and any income
2488 derived from the investment of amounts credited to the fund. There shall be transferred to the
2489 fund any money in the E-Health Institute Fund as of the effective date of this act. The director of

2490 the division shall seek, to the greatest extent possible, private gifts, grants and donations to the
2491 fund. The division shall hold the fund in an account or accounts separate from other funds. The
2492 fund shall be administered by the executive director of the division without further appropriation;
2493 provided, however, that any disbursement or expenditure from the fund for grants or for
2494 contracts with implementing organizations, as provided in section 15, shall be approved by the
2495 division's board.. Amounts credited to the fund shall be available for reasonable expenditure by
2496 the department, subject to the approval of the division where such approval is required under this
2497 section, for such purposes as the department determines are necessary to support the
2498 dissemination and development of health information technology in the commonwealth,
2499 including, but not limited to, for the grant program established in section 15 and for contracts
2500 with implementing organizations provided for in section 6.

2501 Section 12. Any plan approved by the department and every grantee and implementing
2502 organization that receives monies for the adoption of health information technology shall:

2503 (1) establish a mechanism to allow patients to opt-in to the health information exchange
2504 and to opt-out at any time, including a separate opt-in mechanism relative to information
2505 pertaining to health conditions associated with the human immunodeficiency virus.

2506 (2) maintain identifiable health information in physically and technologically secure
2507 environments by means including, but not limited to: prohibiting the storage or transfer of
2508 unencrypted and non-password protected identifiable health information on portable data storage
2509 devices; requiring data encryption, unique alpha-numerical identifiers and password protection;
2510 and other methods to prevent unauthorized access to identifiable health information;

2511 (3) provide patients the option of, upon request, obtaining a list of individuals and entities
2512 that have accessed their identifiable health information;

2513 (4) develop and distribute to authorized users of the health information exchange and to
2514 prospective exchange participants, written guidelines addressing privacy, confidentiality and
2515 security of health information and inform individuals of what information about them is
2516 available, who may access their information, and the purposes for which their information may
2517 be accessed; and

2518 (5) ensure compliance with all state and federal privacy requirements, including those
2519 imposed by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the
2520 American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45
2521 C.F.R. §§160, 162 and 164.

2522 Section 13. In the event of an unauthorized access to or disclosure of individually
2523 identifiable patient health information by or through the statewide health information exchange
2524 or by or through any technology grantees or implementing organizations funded in whole or in
2525 part from the Massachusetts Health Information Technology Fund established pursuant to
2526 section 11, the operator of such exchange or grantee or contractor shall: (i) report the conditions
2527 of such unauthorized access or disclosure as required by the department; and (ii) provide notice,
2528 as defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days
2529 after such unauthorized access or disclosure, to any person whose patient health information may
2530 have been compromised as a result of such unauthorized access or disclosure, and shall report the
2531 conditions of such unauthorized access or disclosure. Any unauthorized access or disclosures
2532 shall be punishable by the civil penalties as set forth in subsection 18.

2533 Section 14. The ability of any provider to transfer or access all or any part of a patient's
2534 electronic health record under the provisions of this section shall be subject to the patient's
2535 election to participate in the electronic health information exchange as provided in section 12.
2536 Such ability shall also be subject to a separate required election to participate as to any
2537 information relating to human immunodeficiency virus status.

2538 Section 15. Funding for the department's activities shall be through the Massachusetts
2539 Health Information Technology Fund, established in section 11. The department shall develop
2540 mechanisms for funding health information technology, including grant and no interest loan
2541 programs as provided in this section and section 17 to assist health care providers with costs
2542 associated with health information technologies, including electronic health records systems, and
2543 coordinating with other electronic health records projects seeking federal reimbursement.

2544 The department shall pursue and maximize all opportunities to qualify for federal
2545 financial participation under the matching grant program established under the Health
2546 Information Technology for Economic and Clinical Health Act of the American Recovery and
2547 Reinvestment Act of 2009, P.L. 111-5. The department shall consult with the office of Medicaid
2548 to maximize all opportunities to qualify any expenditure for any other federal financial
2549 participation. Applications for funding shall be in the form and manner determined by the
2550 department, and shall include the information and assurances required by the department. The
2551 department may consider, as a condition for awarding grants, the grantee's financial participation
2552 and any other factors it deems relevant.

2553 All grants shall be recommended by the department and subsequently approved by the
2554 division in consultation with the council. The director of the department shall work with

2555 implementing organizations to oversee the grant-making process as it relates to an implementing
2556 organization's responsibilities under its contract with the division. Each recipient of monies from
2557 this program shall: (i) capture and report certain quality improvement data, as determined by the
2558 division; (ii) implement the system fully, including all clinical features, not later than the second
2559 year of the grant; and (iii) make use of the system's full range of features.

2560 Section 16. The department shall file an annual report, not later than January 30, with the
2561 joint committee on health care financing, and the house and senate committees on ways and
2562 means concerning the activities of the department in general and, in particular, describing the
2563 progress to date in implementing a statewide electronic health records system and recommending
2564 such further legislative action as it deems appropriate.

2565 Section 17. (a) The state comptroller shall establish and set up on the books of the
2566 commonwealth the Massachusetts health information technology revolving loan fund, hereinafter
2567 referred to as the fund, for the purpose of providing loan assistance to healthcare providers, as
2568 defined in section 1 of chapter 111, to pay the costs associated with compliance with state and
2569 federal requirements relative to the implementation of health care information technology in the
2570 commonwealth, including, but not limited to, the costs of purchasing, installing and
2571 implementing of electronic health records systems and other health information technology
2572 required by state or federal law. There shall be credited to the fund any appropriations, proceeds
2573 of any bonds or notes of the commonwealth issued for the purpose, or other monies authorized
2574 by the general court and designated thereto; any federal grants or loans; any private gifts, grants
2575 or donations made available; and any income derived from the investment of amounts credited to
2576 the fund. The division shall pursue and maximize all opportunities to qualify for federal financial
2577 participation under the matching grant program established under §3013 of the Health

2578 Information Technology for Economic and Clinical Health Act of the American Recovery and
2579 Reinvestment Act of 2009, P.L. 111-5. The department shall seek, to the greatest extent possible,
2580 private gifts, grants and donations to the fund. The fund shall be held in an account or accounts
2581 separate from other funds. The fund shall be administered by the director of the department
2582 without further appropriation; provided, however, that any disbursement or expenditure from the
2583 fund for loans to healthcare providers shall be approved by the division. Amounts credited to the
2584 fund shall be available for reasonable expenditure by the department, subject to the approval of
2585 the division, for such purposes as the department determines are necessary to support the
2586 dissemination and development of health information technology in the commonwealth,
2587 including, but not limited to, the loan program established in this section. Any funds remaining
2588 in the fund at the end of a fiscal year shall be carried forward into the following fiscal year and
2589 shall remain available for expenditure without further appropriation.

2590 (b) The department shall make available zero interest loan funding from the
2591 Massachusetts health information technology revolving loan fund to healthcare providers, as
2592 defined in section 1 of chapter 111, to assist with the development and implementation of an
2593 interoperable health information technology system that meets all federal and state requirements.
2594 The department shall make such loans available through banks approved to do business in the
2595 commonwealth by the division of banks. The department shall enter into agreements with such
2596 lenders to make loans. The department, in consultation with the state treasurer, shall develop a
2597 lender partnership program and lender agreement that requires, at a minimum, (i) that a bank
2598 must be adequately capitalized, consistent with the requirements of 209 CMR 47.00 et seq. and
2599 as defined under the prompt corrective action provisions of the Federal Deposit Insurance Act,
2600 12 U.S.C. § 1831(o), and the Federal Deposit Insurance Corporation's Capital Adequacy

2601 Regulations, 12 CFR § 325.103; (ii) the department shall specify lending standards, including
2602 without limitation, those for determining eligibility, including the eligibility standards set forth in
2603 this subsection, size and number of loans, and (iii) that all loans made under the program must be
2604 zero interest loans provided, however, .that any such program may provide for reasonable
2605 application and administrative fees to be paid to lending banks under the program. A reasonable
2606 amount of administrative costs may be expended annually from the fund for the administration of
2607 the program. Any application or other fees imposed and collected under this program shall be
2608 deposited in the Massachusetts health information technology revolving loan fund for the
2609 duration of the loan program. The department may make such adjustments as are necessary to
2610 loan applications to account for reimbursements received under any other state or federal
2611 programs. To be eligible for a loan under this section, a healthcare provider, at a minimum, must
2612 provide the participating lending institution with the following information: (1) the amount of the
2613 loan requested and a description of the purpose or project for which the loan proceeds will be
2614 used; (2) a price quote from a vendor; (3) a description of the health care provider/entities and
2615 other groups participating in the project; (4) evidence of financial condition and ability to repay
2616 the loan; and (5) a description of how the loan funds will be used to bring the healthcare provider
2617 into compliance with federal and state requirements. Loans shall be repaid over a five-year term
2618 according to a schedule to be established through division regulations. The attorney general shall
2619 enforce collection of any loans in default.

2620 The division shall promulgate regulations necessary for the operation of this program.

2621 Section 18. Unauthorized access to or disclosure of individually identifiable patient
2622 health information by or through the statewide health information exchange or by or through any
2623 technology grantees or implementing organizations funded in whole or in part from the

2624 Massachusetts Health Information Technology Fund, or any associated businesses managing or
2625 in possession of such information, established pursuant to section 11, the operator of such
2626 exchange or grantee or contractor shall be subject to the following fines and penalties. The
2627 division shall promulgate regulations to assess fair and reasonable fines or penalties.

2628 Section 19. The division shall adopt regulations requiring hospitals, clinics, and health
2629 care networks to implement evidence-based best practice clinical decision support tools for the
2630 ordering provider of advanced diagnostic imaging services by January 1, 2017. The clinical
2631 decision support guidelines and protocols developed by the division shall encourage the use of
2632 electronic order entry for advanced imaging services using web-based interfacing between
2633 decision support tools and the software used for electronic order entry, whether it be the
2634 electronic health record system or other health information technology tool. The use of such
2635 decision support tools shall meet the privacy and security standards promulgated pursuant to the
2636 federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-119).

2637 For the purpose of this section, advanced diagnostic imaging services shall include
2638 computerized tomography, magnetic resonance imaging, magnetic resonance angiography,
2639 positive emission tomography, cardiac imaging, ultrasound diagnostic imaging, and such other
2640 imaging services as may be determined by the division.

2641 SECTION 74. Section 2 of chapter 118I is hereby repealed.

2642 SECTION 75. The General Laws are hereby amended by inserting after chapter 118I the
2643 following chapter:-

2644 CHAPTER 118J. ACCOUNTABLE CARE ORGANIZATIONS

2645 Section 1. As used in this chapter, the following words shall, unless the context clearly
2646 requires otherwise, have the following meanings:—

2647 “Accountable Care Organization” or “ACO”, an entity comprised of health care providers
2648 organized into an integrated organization that accepts shared risk for the cost and quality of a
2649 patient’s well being.

2650 “ACO Participant”, a health care provider that either integrates or contracts with an ACO
2651 to provide services to ACO patients.

2652 “ACO Patient”, an individual who chooses or is attributed to an ACO for his course of
2653 medical treatment, for whom such services are paid by the payer to the ACO.

2654 “Alternative Payment Methodology”, methods of payment that are used to reimburse for
2655 services. These types of payments may include, but not limited to global payments, shared
2656 savings arrangements, bundled payments, and episodic payments.

2657 “Division”, the division of health care cost and quality, as enabled in chapter 118G

2658 “Executive Director”, the executive director of the division of health care cost and
2659 quality, as enabled in chapter 118G

2660 “Health Care Provider”, a provider of medical of health services and any other person or
2661 organization, including ACO, that furnishes, bills, or is paid for health care service delivery in
2662 the normal course of business.

2663 “Office of patient protection”, the office within the division of health care cost and
2664 quality established under section 65 of chapter 118G.

2665 “Patient Centered Medical Home”, a model of health care delivery designed to provide a
2666 patient with a single point of coordination for all their health care, including primary, specialty,
2667 post-acute and chronic care, which is (a) patient-centered; (b) comprehensive, integrated and
2668 continuous; and (c) delivered by a team of health care professionals to manage a patient’s care,
2669 reduce fragmentation, and improve patient outcomes.

2670 “Payer”, any entity, other than an individual, that pays providers or ACOs for the
2671 provision of health care services. It shall include both governmental and private entities, but
2672 excludes ERISA plans.

2673 “Physician”, a medical doctor licensed to practice medicine in the commonwealth.

2674 “Primary Care Physician”, a physician who has a primary specialty designation of
2675 internal medicine, general practice, family practice, pediatric practice or geriatric practice.

2676 Section 2. (a) The division shall be responsible for licensing of ACOs. The license shall
2677 be issued for a term of 2 years and renewable under like terms. The ACO shall be in compliance
2678 with all state and federal laws such as the Americans with Disabilities Act, Health Information
2679 Privacy and Accountability Act, and Patient Protection and Affordable Care Act. The division
2680 shall develop the process for licensing ACOs.

2681 (b) A licensed ACO shall, at a minimum, meet the following:

2682 (1) Be a separate legal entity as required in Section 3;

2683 (2) Submit a collaborative care plan as defined in Section 4;

2684 (3) Meet the functional capabilities under Section 6;

- 2685 (4) Have a governance structure under Section 7;
- 2686 (5) Meet the criteria for size under Section 8;
- 2687 (6) Obtain interoperable health information technology under Section 9;
- 2688 (7) Meet the quality reporting requirements under Section 10;
- 2689 (8) Obtain a risk certificate from the Division of Insurance as defined by Section 12;
- 2690 (9) Create internal consumer protection guidelines as defined in Section 13; and
- 2691 (10) Meet pricing reporting requirements under Section 15.
- 2692 (c) The division may include additional requirements for ACO licensure.
- 2693 (d) No later than 30 days after an application has been filed, the division may require the
- 2694 ACO applicant to provide additional information to complete or supplement the filing.
- 2695 (e) Within 45 days of receipt of a complete application, the division shall complete its
- 2696 review of the application and send written notice to the ACO, with a copy to the division of
- 2697 insurance, explaining its decision to: (1) issue the license as applied for, (2) reject the application
- 2698 for failure to comply with the requirements of the application process, with instructions that the
- 2699 application may be resubmitted within 10 days; or (3) deny the application.
- 2700 (f) Any ACO's whose application has been rejected or denied may request an
- 2701 adjudicatory hearing pursuant to chapter 30A within 21 days of the division's decision. The
- 2702 division shall notify the attorney general and the division of insurance upon receipt of such
- 2703 hearing request. Said hearing shall be conducted within 30 days of the division's receipt of the
- 2704 hearing request. The attorney general may intervene in a hearing under this subsection and may

2705 require the production of additional information or testimony. The commissioner shall issue a
2706 written decision within 30 days of the conclusion of the hearing.

2707 (g) An ACO aggrieved by said written decision may, within 20 days of said decision, file
2708 a petition for review in the Suffolk superior court. Review by the supreme judicial court on the
2709 merits shall be limited to the record of the proceedings before the commissioner and shall be
2710 based upon the standards set forth in paragraph (7) of section 14 of chapter 30A.

2711 Section 3. An ACO shall be incorporated or registered in the commonwealth.

2712 Section 4. ACOs shall accept and share among their ACO participants responsibility for
2713 the delivery, management, quality, and cost of the provision of at least all integrated health care
2714 services, as such terms are defined by the division's authority under section 6, to ACO patients.
2715 The ACO shall submit a collaborative care plan for integrating health care and mental health
2716 services. The plan shall include and describe the minimal functional capabilities as defined in
2717 section 6. The division may reject a collaborative care plan if it fails to meet the minimum
2718 benefits or significantly fails to meet to goal of reducing health care costs.

2719 Section 5. ACOs shall be compensated by an alternative payment methodology for each
2720 ACO patient receiving services through the ACO, in accordance with this chapter and any
2721 regulations adopted by division as consistent as possible with federal law, regulations and rules.

2722 Section 6. The division shall have the authority to determine the minimum services
2723 offered by an ACO. The minimum services shall be promulgated in regulation. ACOs shall, at a
2724 minimum, provide or obtain through contractual arrangements the following functional
2725 capacities:

2726 (a) Clinical service coordination, management, and delivery functions, including the
2727 ability to provide integrated health care services through its ACO participant network in
2728 accordance with the principles of a patient centered medical home. Provided that clinical service
2729 coordination may be managed by a physician, a nurse practitioner, a registered nurse, physician
2730 assistant, or social worker.

2731 (b) Population management functions, including health information technology and data
2732 analysis tools to provide at least: (1) patient-specific encounter data and (2) management reports
2733 on aggregate data.

2734 (c) Financial management capabilities, including but not limited to the management of
2735 claims processing and payment functions for ACO participants.

2736 (d) Contract management capabilities, including but not limited to ACO participant
2737 contracting and management functions.

2738 (e) Quality measure competence, including but not limited to the ability to measure and
2739 report performance relative to established measures of quality and performance under standard
2740 quality measures as determined under section 10.

2741 (f) Provider and provider communications functions.

2742 (g) The ability to provide chronic disease management either internally within the ACO
2743 or by contractual agreement.

2744 (h) The ability to provide behavioral health services either internally within the ACO or
2745 by contractual agreement.

2746 (i) The ability to engage patients in shared decision making processes on long-term-care
2747 and supports and palliative care.

2748 (j) Contract with providers for any other medically necessary, but unavailable within the
2749 ACO, services or provide the patient with the ability to receive these services outside of the
2750 ACO.

2751 Section 7. (a) An ACO's organizational structure shall include a governance body,
2752 executive officer, and a medical director.

2753 (b) The governance body shall be identifiable and have the authority to execute functions
2754 for the following:

2755 (1) The governance body shall be responsible for oversight and strategic direction of the
2756 ACO, holding the management accountable for the ACO's activities;

2757 (2) The governance body shall have a transparent governing process;

2758 (3) The governance body members shall have a fiduciary duty and must act consistently
2759 with that fiduciary duty;

2760 (4) The governance body shall be separate and unique to the ACO in cases where the
2761 ACO comprises of multiple, otherwise independent ACO participants; and

2762 (5) If the ACO is an existing entity, the governing body may be the same as the existing
2763 entity provided it satisfies the other requirements of this section.

2764 (c) The governance body shall adhere to the following rules:

2765 (1) At least 75% of the body's control shall be held by ACO participants;

2766 (2) The members of the governance body may serve in a similar or complementary
2767 manner for an ACO participant;

2768 (3) Members of the governance body shall not have a financial conflict of interest;

2769 (4) The governance body shall include at least one patient who does not have a financial
2770 conflict of interest with the ACO; and

2771 (5) The division shall have the discretion to allow a waiver and shall promulgate
2772 regulations for the possibility of waiving any of these requirements.

2773 (d) The executive officer shall be responsible for the administrative and operational
2774 systems to align the ACO with the goals of improving access, improving quality and reducing
2775 costs. The executive officer may be an executive, officer, manager, or general partner. The
2776 executive officer shall consult with the medical director to ensure care coordination and quality.

2777 (e) The medical director shall be responsible for the clinical management and oversight
2778 of the ACO. The medical director shall be a board-certified and licensed physician in the
2779 commonwealth. The medical director shall be an active ACO participant who is physically
2780 present on a regular basis at any clinic, office, or other location participating in the ACO.

2781 Section 8. (a) An ACO shall have a minimum of 15,000 covered lives. A patient shall
2782 voluntarily select to join an ACO and shall count as a covered life for that ACO. An ACO may
2783 not exclude a patient who receives coverage through a program offered by the division of
2784 medical assistance.

2785 (b) An ACO shall have a cap of 400,000 covered lives. They may waive this requirement
2786 under the following conditions:

2787 (1) The attorney general makes an annual determination that the size would not foster
2788 anti-competitive behavior;

2789 (2) The ACO demonstrates an improvement in quality to the division; and

2790 (3) The ACO shows a reduction in total medical expenses to the division.

2791 (c) The division, in consultation with the division of insurance, shall create an annual
2792 open enrollment period for a patient to join an ACO. This period shall last no less than 1 month
2793 and no longer than 2 months. The division shall allow a patient to switch an ACO once within
2794 the first 3 months of coverage in the initial ACO.

2795 Section 9. The ACO shall have an interoperable electronic medical record system
2796 available for ACO participants to coordinate care, share information and electronic prescribing
2797 capabilities by January 1, 2017. The division, in consultation with the Health Information
2798 Technology Council for technical advice, shall promulgate regulations related to electronic
2799 medical records including, but not limited to the standards of interoperability, care coordination
2800 tools, information processes or electronic prescribing standards.

2801 Section 10. (a) The division shall use the standard quality measure set and set minimum
2802 standards that ACOs are responsible for maintaining.

2803 (b) ACOs shall report the quality measures to the division on a semi-annual basis. Failure
2804 to submit a timely report shall result in a fine of \$100 per day up to \$5,000 per missed reporting
2805 period.

2806 (c) The division may conduct an on-site audit of the ACO's quality reporting no more
2807 than twice a year unless the division deems additional audits are required in the interest of public
2808 safety.

2809 (d) The division may fine ACOs up to \$1 per attributed member for failure to meet
2810 quality measures in each reporting period. The ACO shall create and file a quality corrective
2811 action plan with the division if it fails to meet the quality measures in any given reporting period.
2812 The division may revoke an ACO's license if 1) it fails to timely file its corrective action plan, 2)
2813 fails to follow the corrective action plan in a following reporting period, or 3) it fails to meet the
2814 quality measures for 3 consecutive reporting periods.

2815 Section 11. (a) Notwithstanding any other law or regulation to the contrary, the ACO
2816 shall be held liable up to the amount of \$500,000 for any medical malpractice based claim
2817 against an ACO participant acting on behalf of the ACO.

2818 (b) Interest on a legal judgment against an ACO shall be assessed in accordance to
2819 section 60K of chapter 231.

2820 Section 12. The commissioner of insurance shall make a determination that an ACO has
2821 adequate reserves to meet their risk arrangements. The commissioner of insurance shall
2822 promulgate regulations to ensure the viability of an ACO for risks including, but not limited to
2823 global payment risk or enterprise liability based risks. Upon the satisfaction of the commissioner
2824 of insurance, the division of insurance shall submit a certificate of approval to the division.

2825 Section 13. The division shall create guidelines for ACOs to create internal appeals plans
2826 for denial of care. These guidelines shall include the clear articulation of the appellate stages,
2827 timing requirements for each stage of appeal, the process for second opinions to occur outside of

2828 the ACO. The final decision within the ACO shall be completed within 14 days after the filing of
2829 a complaint by a patient. The division may require ACOs to create an ombudsman office or
2830 similar office for the protection of patients. Once appeals within the ACO have been exhausted
2831 internally, the claims shall be appealable to the office of patient protection.

2832 Section 14. Every ACO shall develop and file an internal appeals plan according to
2833 section 13. The division shall approve each plan. The plan shall be a part of a membership packet
2834 for newly enrolled individuals.

2835 Section 15. The division shall require ACOs to report pricing of services by its ACO
2836 participants. The division shall require the reporting of these prices to inform the consumer under
2837 section 50 of chapter 118G. ACO participants shall have the ability to provide patients with
2838 relevant price information when contemplating their care and potential referrals.

2839 SECTION 76. Chapter 149 of the General Laws, as so appearing, is hereby amended by
2840 striking out section 188 and inserting in place thereof the following section:—

2841 Section 188. (a) As used in this section, the following words, unless the context clearly
2842 requires otherwise, shall have the following meanings:--

2843 “Authority”, the commonwealth health insurance connector authority.

2844 "Contributing employer", an employer that offers a group health plan, as defined in 26
2845 U.S.C. 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as
2846 defined in regulation by the division of health care finance and policy.

2847 "Department", the department of unemployment assistance.

2848 "Employer", an employing unit as defined in section 1 of chapter 151A or in section 1 of
2849 chapter 152.

2850 "Employee", any individual employed by an employer subject to this chapter for at least 1
2851 month, provided that for the purpose of this section self-employed individuals shall not be
2852 considered employees.

2853 (b) For the purpose of more equitably distributing the costs of health care provided to
2854 uninsured residents of the commonwealth, each employer that (i) employs 11 or more full-time
2855 equivalent employees in the commonwealth and (ii) is not a contributing employer shall pay a
2856 per-employee contribution at a time and in a manner prescribed by the director of unemployment
2857 assistance, in this section called the fair share employer contribution. This contribution shall be
2858 pro-rated by a fraction which shall not exceed 1, the numerator of which is the number of hours
2859 worked in the quarter by all of the employer's employees and the denominator of which is the
2860 product of the number of employees employed by an employer during that quarter multiplied by
2861 500 hours.

2862 (c) The executive director of the authority, shall, in consultation with the director of
2863 unemployment assistance, annually determine the fair share employer contribution rate based on
2864 the best available data and under the following provisions:--

2865 (1) The per-user share of private sector liability shall be calculated annually by dividing
2866 the sum of hospital liability and third-party payor liability for uncompensated care, as defined by
2867 law, by the total number of individuals in the most recently completed fiscal year whose care
2868 was reimbursed in whole or in part by the uncompensated care pool, or any successor thereto.

2869 (2) The total number of employees in the most recent fiscal year on whose behalf health
2870 care services were reimbursed in whole or in part by the uncompensated care pool, or any
2871 successor thereto, shall be calculated. In calculating this number, the authority shall use all
2872 resources available to enable it to determine the employment status of individuals for whom
2873 reimbursements were made, including quarterly wage reports maintained by the department of
2874 revenue.

2875 (3) The total number of employees as calculated in paragraph (2) shall be adjusted by
2876 multiplying that number by the percentage of employers in the commonwealth that are not
2877 contributing employers, as determined by the authority.

2878 (4) The total cost of liability associated with employees of non- contributing employers
2879 shall be determined by multiplying the number of employees, as calculated in paragraph (3) by
2880 the per-user share of private sector liability as calculated in paragraph (1).

2881 (5) The fair share employer contribution shall be calculated by dividing the total cost of
2882 liability as calculated in paragraph (4) by the total number of employees of employers that are
2883 not contributing employers, as determined by the authority.

2884 (6) The fair share employer contribution, as determined in paragraph (5) shall be adjusted
2885 annually to reflect medical inflation, using an appropriate index as determined by the authority.

2886 (7) The total dollar amount of health care services provided by physicians to non-elderly,
2887 uninsured residents of the commonwealth for which no reimbursement is made from the Health
2888 Safety Net Trust Fund shall be calculated using a survey of physicians or other data source that
2889 the authority determines is most accurate.

2890 (8) The per-employee cost of uncompensated physician care shall be calculated by
2891 dividing the dollar amount of such services, as calculated in paragraph (7) by the total number of
2892 employees of contributing employers in the commonwealth, as estimated by the division using
2893 the most accurate data source available, as determined by the authority.

2894 (9) The annual fair share employer contribution shall be calculated by adding the fair
2895 share employer contribution as calculated in paragraph (6) and the per-employee cost of
2896 unreimbursed physician care, as calculated in paragraph (8).

2897 (10) Notwithstanding this section, the total annual fair share employer contribution shall
2898 not exceed \$295 per employee which may be made in a single payment, or in equal amounts
2899 semi-annually or quarterly, at the employer's discretion.

2900 (d) The director of unemployment assistance shall determine quarterly each employer's
2901 liability for its fair share employer contribution. The director shall assess each employer liable
2902 for a fair share employer contribution in a quarter an amount based on 25 per cent of the annual
2903 fair share employer contribution rate applicable to that quarterly period and shall implement
2904 penalties for employers who fail to make contributions as required by this section. In order to
2905 reduce the administrative costs of collection of contributions, the director shall, to the extent
2906 possible, use any existing procedures that have been implemented by the department of
2907 unemployment assistance to make similar collections. Amounts collected pursuant to this section
2908 shall be deposited in the Commonwealth Care Trust Fund, established by section 2000 of
2909 chapter 29. Before depositing the amounts, the director may deduct all administrative costs
2910 incurred by the department of unemployment assistance as a result of this section, including an
2911 amount as determined by the United States Secretary of Labor in accordance with federal cost

2912 rules. Except where inconsistent with this section, the terms and conditions of chapter 151A
2913 which are applicable to the payment and collection of contributions shall apply to the same
2914 extent to the payment and collection of any obligation under this section. The department of
2915 unemployment assistance shall promulgate regulations necessary to implement this section.

2916 (e) In promulgating regulations defining the term "contribution" under this section, no
2917 proposed regulation by the authority, except an emergency regulation, shall take effect until 60
2918 days after the proposed regulations have been transmitted to the joint committees on health care
2919 financing and financial services.

2920 SECTION 77. Section 1 of chapter 175 of the General Laws is hereby amended by
2921 inserting after the definition of "unearned premiums" the following definition:—

2922 "Wellness Program", a wellness program receiving a seal of approval under section 206A
2923 of chapter 111.

2924 SECTION 78. Section 108 of chapter 175 is hereby amended by inserting after clause 12,
2925 the following clause:—

2926 13. Any policy of accident and sickness shall include a premium rate adjustment based on
2927 employee participation in a wellness program.

2928 SECTION 79. Chapter 175 of the General Laws is hereby amended by inserting after
2929 section 108J the following 2 sections:-

2930 Section 108K. Pursuant to section 50 of chapter 118G, carriers shall provide a toll-free
2931 number and website that enables consumers to request and obtain from the carrier in real time the
2932 maximum estimated amount the insured will be responsible to pay for a proposed admission,

2933 procedure or service that is a medically necessary covered benefit , based on the information
2934 available to the carrier at the time the request is made, including any copayment, deductible,
2935 coinsurance or other out of pocket amount for any health care benefits.

2936 Section 108L. Pursuant to section 50 of chapter 118G, carriers shall disclose patient-level
2937 data including, but not limited to, health care service utilization, medical expenses,
2938 demographics, and where services are being provided, to all providers in their network, provided
2939 that data shall be limited to patients treated by that provider, so as to aid providers in managing
2940 the care of their own patient panel.

2941 SECTION 80. Chapter 175 of the General Laws is hereby amended by inserting after
2942 section 226 the following 2 sections:-

2943 Section 227. As used in this section, the following words shall have the following
2944 meanings:

2945 “Self-insured group,” a self-insured or self-funded employer group health plan.

2946 “Third-party administrator,” an entity that administers payments for health care services
2947 on behalf of a client plan in exchange for an administrative fee.

2948 Pursuant to section 50 of chapter 118G, every third-party administrator shall disclose to
2949 their self-insured group clients contracted prices and quality of services of in-network providers.

2950 Section 228. Carriers shall attribute every member to a primary care provider.

2951 SECTION 81. Chapter 176A of the General Laws is hereby amended by inserting after
2952 section 34 the following 3 sections:—

2953 Section 35. Pursuant to section 50 of chapter 118G, every non-profit hospital service
2954 corporation shall provide a toll-free number and website that enables consumers to request and
2955 obtain from the non-profit hospital service corporation in real time the maximum estimated
2956 amount the insured will be responsible to pay for a proposed admission, procedure or service that
2957 is a medically necessary covered benefit, based on the information available to the carrier at the
2958 time the request is made, including any copayment, deductible, coinsurance or other out of
2959 pocket amount for any health care benefits.

2960 Section 36. Every non-profit hospital service corporation shall attribute every member to
2961 a primary care provider.

2962 Section 37. Pursuant to section 50 of chapter 118G, every non-profit hospital service
2963 corporation shall disclose patient-level data including, but not limited to, health care service
2964 utilization, medical expenses, demographics, and where services are being provided, to all
2965 providers in their network, provided that data shall be limited to patients treated by that provider,
2966 so as to aid providers in managing the care of their own patient panel.

2967 SECTION 82. Chapter 176B of the General Laws is hereby amended by inserting after
2968 section 22 the following 3 sections:-

2969 Section 23. Pursuant to section 50 of chapter 118G, every medical service corporation
2970 shall provide a toll-free number and website that enables consumers to request and obtain from
2971 the medical service corporation in real time the maximum estimated amount the insured will be
2972 responsible to pay for a proposed admission, procedure or service that is a medically necessary
2973 covered benefit, based on the information available to the carrier at the time the request is made,

2974 including any copayment, deductible, coinsurance or other out of pocket amount for any health
2975 care benefits.

2976 Section 24. Every medical service corporation shall attribute every member to a primary
2977 care provider.

2978 Section 25. Pursuant to section 50 of chapter 118G, every medical service corporation
2979 shall disclose patient-level data including, but not limited to, health care service utilization,
2980 medical expenses, demographics, and where services are being provided, to all providers in their
2981 network, provided that data shall be limited to patients treated by that provider, so as to aid
2982 providers in managing the care of their own patient panel.

2983 SECTION 83. Chapter 176G of the General Laws is hereby amended by inserting after
2984 section 30 the following 3 sections:—

2985 Section 31. Pursuant to section 50 of chapter 118G, every health maintenance
2986 organization shall provide a toll-free number and website that enables consumers to request and
2987 obtain from the health maintenance organization in real time the maximum estimated amount the
2988 insured will be responsible to pay for a proposed admission, procedure or service that is a
2989 medically necessary covered benefit, based on the information available to the carrier at the time
2990 the request is made, including any copayment, deductible, coinsurance or other out of pocket
2991 amount for any health care benefits.

2992 Section 32. Every health maintenance organization shall attribute every member to a
2993 primary care provider.

2994 Section 33. Pursuant to section 50 of chapter 118G, every health maintenance
2995 organization shall disclose patient-level data including, but not limited to, health care service
2996 utilization, medical expenses, demographics, and where services are being provided, to all
2997 providers in their network, provided that data shall be limited to patients treated by that provider,
2998 so as to aid providers in managing the care of their own patient panel.

2999 SECTION 84. Paragraph (5) of subsection (a) of section 3 of chapter 176J, as appearing
3000 in the official 2010 edition, is hereby amended by striking out, in line 59, the word “may” and
3001 inserting in place thereof the following word:—“shall”.

3002 SECTION 85. Subsection (a) of section 11 of chapter 176J, as appearing in the 2010
3003 edition, is hereby amended by inserting, in line 60, after the word “providers” the following
3004 clause:—, smart tiering plan in which health services are tiered and member cost sharing is based
3005 on the tier placement of the services,

3006 SECTION 86. Subsection (b) of section 11 of chapter 176J is hereby amended at the end
3007 of the first paragraph by adding the following 2 sentences:—

3008 Smart tiering plans may take into account the number of services performed each year by
3009 the provider. For smart tiering plans, if a medically necessary and covered service is available at
3010 only one facility in the state, as determined by the division of health care cost and quality, that
3011 service shall not be placed into the most expensive cost-sharing tier.

3012 SECTION 87. Section 11 of Chapter 176J is hereby amended by inserting after
3013 subsection (g) the following new 3 subsections:—

3014 (h) A smart tiering plan shall be a tiering product, which offers a cost-sharing differential
3015 based on services rather than facilities providing services. A service covered in a smart tiering
3016 plan may be reimbursed through bundled payments for acute and chronic diseases.

3017 (i) The division shall review smart tiering plans in a manner consistent with other
3018 products offered in the commonwealth. The division may disapprove a smart tiering plan if it
3019 determines that the carrier differentiated cost-sharing obligations solely based on the provider.
3020 There shall be a rebuttable presumption that a plan has violated this subsection if the cost-sharing
3021 obligation for all services provided by a provider, including health care facility, accountable care
3022 organization, patient centered medical home, or provider organization is the same.

3023 (j) The commissioner when developing smart tiering plans shall promote the following
3024 goals: 1) smart tiering plans should avoid creating consumer confusion, 2) it should minimize the
3025 administrative burdens on payers and providers in implementing smart tiering plans, 3) it should
3026 allow patients to get their services in the proper locations.

3027 SECTION 88. Section 11 of chapter 176J, as so appearing, is hereby amended by striking
3028 out, in line 13, the figure “12” and inserting in place thereof the following figure:—16

3029 SECTION 89. Section 11 of chapter 176J, as so appearing, is hereby amended by striking
3030 out, in line , the figure “12” and inserting in place thereof the following figure:—16

3031 SECTION 90. Section 11 of chapter 176J, as appearing, is hereby amended by inserting
3032 the following sentence at the end of subsection (a):—The board of the division shall determine
3033 the base rate discount on an annual basis.

3034 SECTION 91. Chapter 176J of the General Laws is hereby amended by inserting after
3035 section 13 the following 3 sections:-

3036 Section 14. Pursuant to section 50 of chapter 118G, carriers shall provide a toll-free
3037 number and website that enables consumers to request and obtain from the carrier in real time the
3038 maximum estimated amount the insured will be responsible to pay for a proposed admission,
3039 procedure or service that is a medically necessary covered benefit, based on the information
3040 available to the carrier at the time the request is made, including any copayment, deductible,
3041 coinsurance or other out of pocket amount for any health care benefits.

3042 Section 15. Carriers shall attribute every member to a primary care provider.

3043 Section 16. Pursuant to section 50 of chapter 118G, every carrier shall disclose patient-
3044 level data including, but not limited to, health care service utilization, medical expenses,
3045 demographics, and where services are being provided, to all providers in their network, provided
3046 that data shall be limited to patients treated by that provider, so as to aid providers in managing
3047 the care of their own patient panel.

3048 SECTION 92. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby
3049 amended by inserting after the definition of “Adverse determination” the following definition:—

3050 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health
3051 care provider for health care services.

3052 SECTION 93. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby
3053 amended by inserting after the definition of “Person” the following definition:-

3054 “Primary care provider”, a health care professional qualified to provide general medical
3055 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
3056 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
3057 maintains continuity of care within the scope of practice.

3058 SECTION 94. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby
3059 further amended by inserting after the definition of “Health care services” the following new
3060 definition:—

3061 “Hospital-based physician”, a pathologist, anesthesiologist, radiologist or emergency
3062 room physician who practices exclusively within the inpatient or outpatient hospital setting and
3063 who provides health care services to a carrier’s insured only as a result of the insured being
3064 directed to the hospital inpatient or outpatient setting. This definition may be expanded, after
3065 consultation with a statewide advisory committee composed of an equal number of organizations
3066 representing providers and those representing health plans including but not limited to a
3067 representative from the Massachusetts Medical Society, the Massachusetts Hospital Association,
3068 the Massachusetts Association of Health Plans, the Massachusetts Association of Medical Staff
3069 Services, and Blue Cross Blue Shield of Massachusetts, by regulation to include additional
3070 categories of physicians who practice exclusively within the inpatient or outpatient hospital
3071 setting and who provide health care services to a carrier’s insured only as a result of the insured
3072 being directed to the hospital inpatient or outpatient setting.

3073 SECTION 95. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby
3074 further amended in lines 126 to 128 by striking out the definition of “Office of patient
3075 protection” and inserting in place thereof the following:—

3076 “Office of patient protection”, the office in the division of health care cost and quality
3077 established by section 65 of chapter 118G, responsible for the administration and enforcement of
3078 sections 13, 14, 15 and 16.

3079 SECTION 96. Section 2 of chapter 176O of the General Laws, as so appearing, is hereby
3080 amended by striking out subsection (c) and inserting in place thereof the following subsection:—

3081 (c) Regulations promulgated by the bureau shall be consistent with and not duplicate or
3082 overlap with the regulations promulgated by the office of patient protection in the division of
3083 health care cost and quality established by section 65 of chapter 118G.

3084 SECTION 97. Chapter 176O of the General Laws is hereby amended by inserting after
3085 section 2 the following 2 new sections:—

3086 Section 2A. (a) The bureau shall adopt a common application for initial credentialing or
3087 appointment and a common application for re-credentialing or reappointment. The bureau, after
3088 consultation with a statewide advisory committee composed of an equal number of organizations
3089 representing providers and those representing health plans including but not limited to a
3090 representative from the Massachusetts Medical Society, the Massachusetts Hospital Association,
3091 the Massachusetts Association of Health Plans, the Massachusetts Association of Medical Staff
3092 Services, and Blue Cross Blue Shield of Massachusetts, a representative of the board of
3093 registration in medicine, a representative of the board of registration in nursing and a
3094 representative of the department of public health, shall adopt and make any revisions to the
3095 common credentialing application forms that includes but is not limited to applicable
3096 accreditation as well as federal and state regulatory changes that will impact such forms. Such
3097 forms shall not be applicable in those instances where the carrier has both delegated

3098 credentialing to a provider organization and does not require submission of a credentialing
3099 application.

3100 (b) A carrier and a participating provider shall not use any initial physician credentialing
3101 application form other than the uniform initial physician application form or a uniform electronic
3102 version of said form. A carrier and a participating provider shall not use any physician re-
3103 credentialing application form other than the uniform physician re-credentialing application form
3104 or a uniform electronic version of said form. A carrier may require that a physician profile be
3105 submitted in addition to the uniform physician re-credentialing application form.

3106 (c) A carrier shall act upon and complete the credentialing process for 95 percent of
3107 complete initial physician credentialing applications submitted by or on behalf of a physician
3108 applicant within 30 calendar days of receipt of a complete application. An application shall be
3109 considered complete if it contains all of the following elements submitted by the physician
3110 applicant or designee or obtained by the carrier from a credentials verification organization
3111 certified by the National Committee for Quality Assurance: —

3112 (i) the application form is signed and appropriately dated by the physician applicant;

3113 (ii) all information on the application is submitted in a legible and complete manner and
3114 any affirmative answers are accompanied by explanations satisfactory to the carrier;

3115 (iii) a current curriculum vitae with appropriate required dates;

3116 (iv) a signed, currently dated Applicant's Authorization to Release Information form;

3117 (v) copies of the applicant's current licenses in all states in which the physician
3118 practices;

3119 (vi) a copy of the applicant's current Massachusetts controlled substances registration
3120 and a copy of the applicant's current federal DEA controlled substance certificate or, if not
3121 available, a letter describing prescribing arrangements;

3122 (vii) a copy of the applicant's current malpractice face sheet coverage statement
3123 including amounts and dates of coverage;

3124 (viii) hospital letter or verification of hospital privileges or alternate pathways;

3125 (ix) documentation of board certification or alternate pathways;

3126 (x) documentation of training, if not board certified;

3127 (xi) there are no affirmative responses on questions related to quality or clinical
3128 competence;

3129 (xii) there are no modifications to the Applicant's Authorization to Release Information
3130 Form;

3131 (xiii) there are no discrepancies between the information submitted by or on behalf of the
3132 physician and information received from other sources; and

3133 (xiv) the appropriate health plan participation agreement, if applicable.

3134 (d) A carrier shall report to a physician applicant or designee the status of a submitted
3135 initial credentialing application within a reasonable timeframe. Said report shall include, but not
3136 be limited to, the application receipt date and, if incomplete, an itemization of all missing or
3137 incomplete items. A carrier may return an incomplete application to the submitter. A physician
3138 applicant or designee shall be responsible for any and all missing or incomplete items.

3139 (e) A carrier shall notify a physician applicant of the carrier's credentialing committee's
3140 decision on an initial credentialing application within four business days of the decision. Said
3141 notice shall include the committee's decision and the decision date.

3142 (f) A physician, other than a primary care provider compensated on a capitated basis, who
3143 has been credentialed pursuant to the terms of this section shall be allowed to treat a carrier's
3144 insureds and shall be reimbursed by the carrier for covered services provided to a carrier's
3145 insureds effective as of the carrier's credentialing committee's decision date. A primary care
3146 physician compensated on a capitated basis who has been credentialed pursuant to the terms
3147 established in this section shall be allowed to treat a carrier's insureds and shall be reimbursed by
3148 the carrier for covered services provided to the carrier's insureds effective no later than the first
3149 day of the month following the carrier's credentialing committee's decision date.

3150 (g) This section shall not apply to the credentialing and re-credentialing by
3151 carriers of psychiatrists or hospital-based physicians.

3152 Section 2B. (a) The bureau's accreditation requirements related to credentialing and re-
3153 credentialing shall not require a carrier to complete the credentialing or re-credentialing process
3154 for hospital-based physicians.

3155 (b) Except as provided in paragraph (d), a carrier shall not require a hospital-based
3156 physician to complete the credentialing and re-credentialing process established pursuant to the
3157 bureau's accreditation requirements.

3158 (c) A carrier may establish an abbreviated data submission process for hospital-based
3159 physicians. Except as provided in paragraph (d) of this section, said process shall be limited to a

3160 review of the data elements required to be collected and reviewed pursuant to applicable federal
3161 and state regulations as well as national accreditation organization standards.

3162 (d) In the event that the carrier determines that there is a need to further review a
3163 hospital-based physician's credentials due to quality of care concerns, complaints from insureds,
3164 applicable law or other good faith concerns, the carrier may conduct such review as is necessary
3165 to make a credentialing or re-credentialing decision.

3166 (e) Nothing in this section shall be construed to prohibit a carrier from requiring a
3167 physician to submit information or taking other actions necessary for the carrier to comply with
3168 the applicable regulations of the board of registration in medicine.

3169 (f) The bureau, after consultation with a statewide advisory committee composed of an
3170 equal number of organizations representing providers and those representing health plans
3171 including but not limited to a representative from the Massachusetts Hospital Association, the
3172 Massachusetts Medical Society, the Massachusetts Association of Health Plans, the
3173 Massachusetts Association of Medical Staff Services, and Blue Cross and Blue Shield of
3174 Massachusetts, a representative of the board of registration in medicine, a representative of the
3175 board of registration in nursing and a representative of the department of public health, shall
3176 develop standard criteria and oversight guidelines that may be used by carriers to delegate the
3177 credentialing function to providers. Such criteria and oversight guidelines shall meet applicable
3178 accreditation standards.

3179 SECTION 98. Section 6 of chapter 176O, as so appearing, is hereby amended by striking
3180 clause (3) of subsection (a) and inserting in place thereof the following subsection:—

3181 (3) the limitations on the scope of health care services and any other benefits to be
3182 provided, including (i) all restrictions relating to preexisting condition exclusions, and (ii) an
3183 explanation of any facility fee, allowed amount, co-insurance, copayment, deductible, or other
3184 amount, that the insured may be responsible to pay to obtain covered benefits from network or
3185 out-of-network providers.

3186 SECTION 99. Section 6 of chapter 176O of the General Laws, as so appearing, is hereby
3187 further amended by striking out, in lines 52 to 54 paragraph (13) and inserting in place thereof
3188 the following paragraph:—

3189 (13) a statement on how to obtain the report regarding grievances from the office of
3190 patient protection pursuant to paragraph (2) of subsection (a) of section 65 of chapter 118G;

3191 SECTION 100. Section 9A of chapter 176O of the General Laws, as so appearing, is
3192 hereby amended by inserting after subsection (c), the following 2 subsections:—

3193 (d) limits the ability of either the carrier or the health care provider from disclosing the
3194 allowed amount and fees of services to an insured or insured’s treating health care provider.

3195 (e) limits the ability of either the carrier or the health care provider from disclosing out-
3196 of-pocket costs to an insured.

3197 SECTION 101. Section 14 of chapter 176O of the General Laws, as so appearing, is
3198 hereby amended by striking out, in line 6 the words “section 217 of chapter 111” and inserting in
3199 place thereof the following:—section 65 of chapter 118G

3200 SECTION 102. Chapter 176O of the General Laws is hereby amended by striking out
3201 section 15, as so appearing, and inserting in place thereof the following section:—

3202 Section 15. (a) A carrier that allows or requires the designation of a primary care provider
3203 shall notify an insured at least 30 days before the disenrollment of such insured's primary care
3204 provider and shall permit such insured to continue to be covered for health services, consistent
3205 with the terms of the evidence of coverage, by such primary care provider for at least 30 days
3206 after said provider is disenrolled, other than disenrollment for quality-related reasons or for
3207 fraud. Such notice shall also include a description of the procedure for choosing an alternative
3208 primary care provider.

3209 (b) A carrier shall allow any female insured who is in her second or third trimester of
3210 pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled,
3211 other than disenrollment for quality-related reasons or for fraud, to continue treatment with said
3212 provider, consistent with the terms of the evidence of coverage, for the period up to and
3213 including the insured's first postpartum visit.

3214 (c) A carrier shall allow any insured who is terminally ill and whose provider in
3215 connection with said illness is involuntarily disenrolled, other than disenrollment for quality-
3216 related reasons or for fraud, to continue treatment with said provider, consistent with the terms of
3217 the evidence of coverage, until the insured's death.

3218 (d) A carrier shall provide coverage for health services for up to 30 days from the
3219 effective date of coverage to a new insured by a physician who is not a participating provider in
3220 the carrier's network if: (1) the insured's employer only offers the insured a choice of carriers in
3221 which said physician is not a participating provider, and (2) said physician is providing the
3222 insured with an ongoing course of treatment or is the insured's primary care provider. With
3223 respect to an insured in her second or third trimester of pregnancy, this provision shall apply to

3224 services rendered through the first postpartum visit. With respect to an insured with a terminal
3225 illness, this provision shall apply to services rendered until death.

3226 (e) A carrier may condition coverage of continued treatment by a provider under
3227 subsections (a) to (d), inclusive, upon the provider's agreeing (1) to accept reimbursement from
3228 the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to
3229 impose cost sharing with respect to the insured in an amount that would exceed the cost sharing
3230 that could have been imposed if the provider had not been disenrolled; (2) to adhere to the
3231 quality assurance standards of the carrier and to provide the carrier with necessary medical
3232 information related to the care provided; and (3) to adhere to such carrier's policies and
3233 procedures, including procedures regarding referrals, obtaining prior authorization and providing
3234 services pursuant to a treatment plan, if any, approved by the carrier. Nothing in this subsection
3235 shall be construed to require the coverage of benefits that would not have been covered if the
3236 provider involved remained a participating provider.

3237 (f) A carrier that requires an insured to designate a primary care provider shall allow such
3238 a primary care provider to authorize a standing referral for specialty health care provided by a
3239 health care provider participating in such carrier's network when (1) the primary care provider
3240 determines that such referrals are appropriate, (2) the provider of specialty health care agrees to a
3241 treatment plan for the insured and provides the primary care provider with all necessary clinical
3242 and administrative information on a regular basis, and (3) the health care services to be provided
3243 are consistent with the terms of the evidence of coverage. Nothing in this section shall be
3244 construed to permit a provider of specialty health care who is the subject of a referral to
3245 authorize any further referral of an insured to any other provider without the approval of the
3246 insured's carrier.

3247 (g) No carrier shall require an insured to obtain a referral or prior authorization from a
3248 primary care provider for the following specialty care provided by an obstetrician, gynecologist,
3249 certified nurse-midwife or family practitioner participating in such carrier's health care provider
3250 network: (1) annual preventive gynecologic health examinations, including any subsequent
3251 obstetric or gynecological services determined by such obstetrician, gynecologist, certified
3252 nurse-midwife or family practitioner to be medically necessary as a result of such examination;
3253 (2) maternity care; and (3) medically necessary evaluations and resultant health care services for
3254 acute or emergency gynecological conditions. No carrier shall require higher copayments,
3255 coinsurance, deductibles or additional cost sharing arrangements for such services provided to
3256 such insureds in the absence of a referral from a primary care provider. Carriers may establish
3257 reasonable requirements for participating obstetricians, gynecologists, certified nurse-midwives
3258 or family practitioners to communicate with an insured's primary care provider regarding the
3259 insured's condition, treatment, and need for follow-up care. Nothing in this section shall be
3260 construed to permit an obstetrician, gynecologist, certified nurse-midwife or family practitioner
3261 to authorize any further referral of an insured to any other provider without the approval of the
3262 insured's carrier.

3263 (h) A carrier shall provide coverage of pediatric specialty care, including mental health
3264 care, by persons with recognized expertise in specialty pediatrics to insureds requiring such
3265 services.

3266 (i) A carrier, including a dental or vision carrier, shall provide health, dental or vision
3267 care providers applying to be participating providers who are denied such status with a written
3268 reason or reasons for denial of such application.

3269 (j) No carrier shall make a contract with a health care provider which includes a provision
3270 permitting termination without cause. A carrier shall provide a written statement to a provider of
3271 the reason or reasons for such provider's involuntary disenrollment.

3272 (k) A carrier, including a dental or vision carrier, shall provide insureds, upon request,
3273 interpreter and translation services related to administrative procedures.

3274 SECTION 103. Section 20 of chapter 176O of the General Laws, as so appearing, is
3275 hereby amended in lines 26 to 30 by striking out paragraph (iv)(3) and inserting in place thereof
3276 the following paragraph:—

3277 (3) a statement that the office of patient protection, established by section 65 of chapter
3278 118G, is available to assist consumers, a description of the grievance and review processes
3279 available to consumers under chapter 176O, and relevant contact information to access the office
3280 and these processes.

3281 SECTION 104. Chapter 176Q of the General Laws, as so appearing, is hereby amended
3282 by adding the following section:—

3283 Section 17. (a) The authority shall, upon verification of the provision of services and
3284 costs to a state-funded employee, assess a free rider surcharge on the non-providing employer
3285 under regulations promulgated by the authority.

3286 (b) The amount of the free rider surcharge on non-providing employers shall be
3287 determined by the authority under regulations promulgated by the authority, and assessed by the
3288 authority not later than 3 months after the end of each hospital fiscal year, with payment by non-
3289 providing employers not later than 180 days after the assessment. The amount charged by the

3290 authority shall be greater than 10 per cent but no greater than 100 per cent of the cost to the state
3291 of the services provided to the state-funded employee, considering all payments received by the
3292 state from other financing sources for free care; provided that the “cost to the state” for services
3293 provided to any state-funded employee may be determined by the authority as a percentage of
3294 the state’s share of aggregate costs for health services. The free rider surcharge shall only be
3295 triggered upon incurring \$50,000 or more, in any hospital fiscal year, in free care services for
3296 any employer’s employees, or dependents of such persons, in aggregate, regardless of how many
3297 state-funded employees are employed by that employer.

3298 (c) The formula for assessing free rider surcharges on non-providing employers shall be
3299 set forth in regulations promulgated by the authority that shall be based on factors including, but
3300 not limited to: (i) the number of incidents during the past year in which employees of the non-
3301 providing employer received services reimbursed by the health safety net office under section
3302 39; (ii) the number of persons employed by the non-providing employer; (iii) the proportion of
3303 employees for whom the non-providing employer provides health insurance.

3304 (d) If a state-funded employee is employed by more than one non-providing employer at
3305 the time he or she receives services, the authority shall assess a free rider surcharge on each said
3306 employer consistent with the formula established by the authority under this section.

3307 (e) The authority shall specify by regulation appropriate mechanisms for implementing
3308 free rider surcharges on non-providing employers. Said regulations shall include, but not be
3309 limited to, the following provisions:—

3310 (i) Appropriate mechanisms that provide for determination and payment of surcharge by
3311 a non-providing employer including requirements for data to be submitted by employers,
3312 employees, acute hospitals and ambulatory surgical centers, and other persons; and

3313 (ii) Penalties for nonpayment or late payment by the non-providing employer, including
3314 assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of
3315 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.

3316 (f) All surcharge payments made under this section shall be deposited into the
3317 Commonwealth Care Trust Fund, established by section 2000 of chapter 29.

3318 (g) A non-providing employer's liability to that fund shall in the case of a transfer of
3319 ownership be assumed by the successor in interest to the non-providing employer's.

3320 (h) If a non-providing employer fails to file any data, statistics or schedules or other
3321 information required under this chapter or by any regulation promulgated by the authority, the
3322 authority shall provide written notice of the required information. If the employer fails to provide
3323 information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject
3324 to a civil penalty of not more than \$5,000 for each week on which such violation occurs or
3325 continues, which penalty may be assessed in an action brought on behalf of the commonwealth
3326 in any court of competent jurisdiction.

3327 (i) The attorney general shall bring any appropriate action, including injunctive relief, as
3328 may be necessary for the enforcement of this chapter.

3329 (j) No employer shall discriminate against any employee on the basis of the employee's
3330 receipt of free care, the employee's reporting or disclosure of his employer's identity and other

3331 information about the employer, the employee’s completion of a Health Insurance Responsibility
3332 Disclosure form, or any facts or circumstances relating to “free rider” surcharges assessed
3333 against the employer in relation to the employee. Violation of this subsection shall constitute a
3334 per se violation of chapter 93A.

3335 (k) A hospital, surgical center, health center or other entity that provides uncompensated
3336 care pool services shall provide an uninsured patient with written notice of the criminal penalties
3337 for committing fraud in connection with the receipt of uncompensated care pool services. The
3338 authority shall promulgate a standard written notice form to be made available to health care
3339 providers in English and foreign languages. The form shall further include written notice of
3340 every employee’s protection from employment discrimination under this section.

3341 SECTION 105. The General Laws are hereby amended by inserting after chapter 176R
3342 the following chapter:-

3343 CHAPTER 176S

3344 CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

3345 Section 1. As used in this chapter, the following words shall have the following meanings
3346 unless the context clearly requires otherwise:

3347 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health
3348 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
3349 176A; a nonprofit medical service corporation organized under chapter 176B; a health
3350 maintenance organization organized under chapter 176G; an organization entering into a
3351 preferred provider arrangement under chapter 176I; a contributory group general or blanket

3352 insurance for persons in the service of the commonwealth under chapter 32A; a contributory
3353 group general or blanket insurance for persons in the service of counties, cities, towns and
3354 districts, and their dependents under chapter 32B; the medical assistance program administered
3355 by the division of medical assistance pursuant to chapter 118E and in accordance with Title XIX
3356 of the Social Security Act or any successor statute; and any other medical assistance program
3357 operated by a governmental unit for persons categorically eligible for such program.

3358 “Commissioner”, the commissioner of insurance.

3359 “Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a
3360 carrier.

3361 “Nondiscriminatory basis”, a carrier shall be deemed to be providing coverage on a non-
3362 discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service
3363 limitation imposed on coverage for the care provided by a physician assistant which is less than
3364 any annual or lifetime dollar or unit of service limitation imposed on coverage for the same
3365 services by other participating providers.

3366 “Participating provider”, a provider who, under terms and conditions of a contract with
3367 the carrier or with its contractor or subcontractor, has agreed to provide health care services to an
3368 insured with an expectation of receiving payment, other than coinsurance, co-payments or
3369 deductibles, directly or indirectly from the carrier.

3370 “Physician assistant”, a person who is a graduate of an approved program for the training
3371 of physician assistants who is supervised by a registered physician in accordance with sections
3372 9C to 9H, inclusive, of chapter 112, and who has passed the Physician Assistant National
3373 Certifying Exam or its equivalent.

3374 “Primary care provider”, a health care professional qualified to provide general medical
3375 care for common health care problems who (1) supervises, coordinates, prescribes, or otherwise
3376 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
3377 maintains continuity of care within the scope of practice.

3378 Section 2. The commissioner and the group insurance commission shall require that all
3379 carriers recognize physician assistants as participating providers subject to section 3 and shall
3380 include coverage on a nondiscriminatory basis to their insureds for care provided by physician
3381 assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall
3382 include benefits for primary care, intermediate care and inpatient care, including care provided in
3383 a hospital, clinic, professional office, home care setting, long-term care setting, mental health or
3384 substance abuse program, or any other setting when rendered by a physician assistant who is a
3385 participating provider and is practicing within the scope of his professional authority as defined
3386 by statute, rule and physician delegation to the extent that such policy or contract currently
3387 provides benefits for identical services rendered by a provider of health care licensed by the
3388 commonwealth.

3389 Section 3. A participating provider physician assistant practicing within the scope of his
3390 license including all regulations requiring collaboration with or supervision by a physician under
3391 section 9E of chapter 112, shall be considered qualified within the carrier’s definition of primary
3392 care provider to an insured.

3393 Section 4. Notwithstanding any general or special law to the contrary, a carrier that
3394 requires the designation of a primary care provider shall provide its insured with an opportunity
3395 to select a participating provider physician assistant as a primary care provider.

3396 Section 5. Notwithstanding any general or special law to the contrary, a carrier shall
3397 ensure that all participating provider physician assistants are included on any publicly accessible
3398 list of participating providers for the carrier.

3399 Section 6. A complaint for noncompliance against a carrier shall be filed with and
3400 investigated by the commissioner or the group insurance commission, whichever shall have
3401 regulatory authority over the carrier. The commissioner and the group insurance commission
3402 shall promulgate regulations to enforce this chapter.

3403 SECTION 106. Section 60K of chapter 231 of the general laws as so appearing is hereby
3404 amended in line 14 by striking the number “4” and inserting in place thereof the following
3405 number:—2

3406 SECTION 107. Section 85K of chapter 231 of the General Laws, as so appearing, is
3407 hereby amended by inserting after the word “costs” in line 8 with the following:—

3408 ; provided, however, in the context of medical malpractice claims against a non-profit
3409 charity providing health care, such cause of action shall not exceed the sum of \$100,000,
3410 exclusive of interest and costs.

3411 SECTION 108. Chapter 231 of the General Laws is hereby amended by inserting after
3412 section 60K the following 3 sections:—

3413 Section 60L. (a) Except as provided in this section a person shall not commence an action
3414 against a provider of health care as defined in the seventh paragraph of section 60B unless the
3415 person has given the health care provider written notice under this section of not less than 182
3416 days before the action is commenced.

3417 (b) The notice of intent to file a claim required under subsection (a) shall be mailed to the
3418 last known professional business address or residential address of the health care provider who is
3419 the subject of the claim.

3420 (c) The 182 day notice period in subsection (a) is shortened to 91 days if either of the
3421 following conditions exists:

3422 (1) the claimant has previously filed the 182 day notice required against another health
3423 care provider involved in the claim; and

3424 (2) the claimant has filed a complaint and commenced an action alleging medical
3425 malpractice against one or more of the health care providers involved in the claim.

3426 (d) The 182 day notice of intent described in subsection (a) is not required if the claimant
3427 did not identify and could not reasonably have identified a health care provider to which notice
3428 must be sent as a potential party to the action before filing the complaint.

3429 (e) The notice given to a health care provider under this section shall contain a statement
3430 of at least all of the following:

3431 (1) the factual basis for the claim;

3432 (2) the applicable standard of care alleged by the claimant;

3433 (3) the manner in which it is claimed that the applicable standard of care was breached by
3434 the health care provider;

3435 (4) the alleged action that should have been taken to achieve compliance with the alleged
3436 standard of care;

3437 (5) the manner in which it is alleged the breach of the standard of care was a proximate
3438 cause of the injury claimed in the notice; and

3439 (6) the names of all health care providers the claimant is notifying under this section in
3440 relation to the claim.

3441 (f) 56 days after giving notice under this section, the claimant shall allow the health care
3442 provider receiving the notice access to all of the medical records related to the claim that are in
3443 the claimant's control, and shall furnish release for any medical records related to the claim that
3444 are not in the claimant's control, but of which the claimant has knowledge. This subsection does
3445 not restrict a patient's right of access to his or her medical records under any other provision of
3446 law.

3447 (g) Within 150 days after receipt of notice under this section, the health care provider or
3448 authorized representative against whom the claim is made shall furnish to the claimant or his or
3449 her authorized representative a written response that contains a statement including the
3450 following:

3451 (1) the factual basis for the defense, if any, to the claim;

3452 (2) the standard of care that the health care provider claims to be applicable to the action;

3453 (3) the manner in which it is claimed by the health care provider that there was or was not
3454 compliance with the applicable standard of care; and

3455 (4) the manner in which the health care provider contends that the alleged negligence of
3456 the health care provider was or was not a proximate cause of the claimant's alleged injury or
3457 alleged damage.

3458 (h) If the claimant does not receive the written response required under subsection (g)
3459 within the required 150 day time period, the claimant may commence an action alleging medical
3460 malpractice upon the expiration of the 150 day period. Further, if a provider fails to respond
3461 within 150 days and that fact is made known to the Court in the plaintiffs' complaint or by any
3462 other means then interest on any judgment against that provider will accrue and be calculated
3463 from the date that the notice was filed rather than the date that suit is filed. At any time before
3464 the expiration of the 150 day period, the claimant and the provider may agree to an extension of
3465 the 150 day period.

3466 (i) If at any time during the applicable notice period under this section a health care
3467 provider receiving notice under this section informs the claimant in writing that the health care
3468 provider does not intend to settle the claim within the applicable notice period, the claimant may
3469 commence an action alleging medical malpractice against the health care provider, so long as the
3470 claim is not barred by the statute of limitations or repose.

3471 (j) As to any lawsuit against any health care provider(s) filed within six months of the
3472 statute of limitations expiring as to any claimant, or within one year of the statute of repose
3473 expiring as to any claimant, compliance with this section (MGL ch. 231, sec 60L) is not required.

3474 (k) Nothing in this act shall prohibit the filing of suit at any time in order to seek court
3475 orders to preserve and permit inspection of tangible evidence.

3476 Section 60M. In any action for malpractice, negligence, error, omission, mistake or the
3477 unauthorized rendering of professional services against a provider of health licensed pursuant to
3478 section 2 of chapter 112, including actions pursuant to section 60B of this chapter, an expert

3479 witness shall have been engaged in the practice of medicine at the time of the alleged
3480 wrongdoing.

3481 Section 60N. In any action for malpractice, negligence, error, omission, mistake or the
3482 unauthorized rendering of professional services against a provider of health licensed pursuant to
3483 section 2 of chapter 112, including actions pursuant to section 60B of this chapter, an expert
3484 witness shall be board certified in the same specialty as the defendant physician as licensed
3485 pursuant to section 2 of chapter 112.

3486 SECTION 109. Chapter 233 of the General Laws is hereby amended by inserting after
3487 section 79K the following section:-

3488 Section 79L. (a) As used in this section the following terms shall have the following
3489 meaning:

3490 “Health Care Provider”, means any of the following health care professionals licensed
3491 pursuant to chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist,
3492 optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social
3493 worker, speech-language pathologist, audiologist, marriage and family therapist and a mental
3494 health counselor. The term shall also include any corporation, professional corporation,
3495 partnership, limited liability company, limited liability partnership, authority, or other entity
3496 comprised of such health care providers.

3497 “Facility”, a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home
3498 health agency. The term shall also include any corporation, professional corporation,
3499 partnership, limited liability company, limited liability partnership, authority, or other entity
3500 comprised of such facilities.

3501 “Unanticipated outcome” means the outcome of a medical treatment or procedure,
3502 whether or not resulting from an intentional act, that differs from an intended result of such
3503 medical treatment or procedure.

3504 (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly
3505 experiencing an unanticipated outcome of medical care, any and all statements, affirmations,
3506 gestures, activities or conduct expressing benevolence, regret, apology, sympathy,
3507 commiseration, condolence, compassion, mistake, error, or a general sense of concern which are
3508 made by a health care provider, facility or an employee or agent of a health care provider or
3509 facility, to the patient, a relative of the patient, or a representative of the patient and which relate
3510 to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative
3511 proceeding, unless the maker of the statement or a defense expert witness, when questioned
3512 under oath during the litigation about facts and opinions regarding any mistakes or errors that
3513 occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in
3514 which case the statements and opinions made about the mistake or error are admissible for all
3515 purposes. In situations where a patient suffers an unanticipated outcome with significant medical
3516 complication(s) resulting from the provider’s mistake, the health care provider, facility, or an
3517 employee or agent of a health care provider or facility shall fully inform the patient, and when
3518 appropriate the patient's family, about said unanticipated outcome.

3519 SECTION 110. Section 4 of Chapter 260 of the Generals is hereby amended at the end of
3520 the 2nd paragraph in line 28 after the word “body.” by adding the following:—

3521 The statutes of limitation and repose in this paragraph shall be tolled for a period of 180
3522 days when a notice of intent to file a claim, pursuant to section 60L(a) of chapter 231, is sent to
3523 a provider of health care as defined in the seventh paragraph of section 60B of chapter 231.

3524 SECTION 111. Section 1 of chapter 205 of the acts of 2007 is hereby repealed.

3525 SECTION 112. Section 3 of chapter 305 of the acts of 2008 is hereby repealed.

3526 SECTION 113. Section 4 of chapter 305 of the acts of 2008 is hereby repealed.

3527 SECTION 114. Sections 15 and 58 of chapter 305 of the acts of 2008 are hereby
3528 repealed.

3529 SECTION 115. Sections 2 and 3 of chapter 288 of the acts of 2010 are hereby repealed.

3530 SECTION 116. Section 54 of chapter 288 of the Acts of 2010 is hereby repealed.

3531 SECTION 117. Nothing in this act shall be construed to preclude an individual from
3532 obtaining additional insurance or paying out of pocket for any medical service not covered by the
3533 individual's health plan, provided, however, that supplemental insurance may not cover
3534 copayments, deductibles, co-insurance or other patient payment responsibility for services that
3535 are included in the individual's health plan.

3536 SECTION 118. To promote the adoption of alternative payment methodologies and
3537 contracting with ACOs by both private and public purchasers of health care, the division shall,
3538 by August 15, 2012, request from the federal office of the inspector general the following:

3539 (i) a waiver of the provisions of, or expansion of the "safe harbors" to, 42 U.S.C. section
3540 1320a-7b and implementing regulations or any other necessary authorization the division

3541 determines may be necessary to permit certain shared risk and other risk sharing arrangements
3542 among providers and ACOs; and

3543 (ii) a waiver of or exemption from the provisions of 42 U.S.C. section 1395nn(a) to (e)
3544 and implementing regulations or other necessary authorization the division determines may be
3545 necessary to permit physician referrals to other providers as needed to support the transition to
3546 and implementation of global and alternative payment systems and formation of ACOs.

3547 SECTION 119. Notwithstanding any general or special law, rule or regulation to the
3548 contrary, the commissioner of insurance shall promulgate regulations requiring any carrier, as
3549 defined in Chapter 176O of the general laws, and their contractors to effectively comply with and
3550 implement the federal Mental Health Parity and Addiction Equity Act of 2008, Section 511 of
3551 Public Law 110-343. The commissioner of insurance shall promulgate said regulations not later
3552 than 90 days after the effective date of this act. Said regulations shall be implemented as part of
3553 any provider contracts and any carrier's health benefit plans which are delivered, issued, entered
3554 into, renewed, or amended on or after this act's effective date.

3555 Starting on July 1, 2013, the commissioner of insurance shall require all carriers, as so
3556 defined, and their contractors, to submit an annual report to the Division of Insurance, which
3557 shall be a public record, certifying and outlining how their health benefit plans are in compliance
3558 with the federal Mental Health Parity Act and the provisions of this section. The division of
3559 insurance shall forward all such reports to the office of the attorney general for verification of
3560 compliance with the federal Mental Health Parity Act.

3561 SECTION 120. Notwithstanding any general or special law, rule or regulation to the
3562 contrary, the office of Medicaid shall promulgate regulations requiring any Medicaid health plan

3563 and managed care organization and their health plans and any behavioral health management
3564 firm and third party administrator under contract with a Medicaid managed care organization to
3565 effectively comply with and implement the federal Mental Health Parity and Addiction Equity
3566 Act of 2008, Section 511 of Public Law 110-343. The office of Medicaid shall promulgate said
3567 regulations not later than 90 days after the effective date of this act. Said regulations shall be
3568 implemented as part of any provider contracts and any carrier's health benefit plans which are
3569 delivered, issued, entered into, renewed, or amended on or after this act's effective date.

3570 Starting on July 1, 2013, the Office of Medicaid shall submit an annual report to the co-
3571 chairs of the Joint Committee on Health Care Financing, the co-chairs of the Joint Committee on
3572 Mental Health and Substance Abuse, the clerk of the Senate, and the clerk of the House of
3573 Representatives certifying and outlining how the health benefit plans under the Office of
3574 Medicaid, and any contractors, are in compliance with the federal Mental Health Parity Act and
3575 the provisions of this section. The office of Medicaid shall forward all such reports to the office
3576 of the attorney general for verification of compliance with the federal Mental Health Parity Act.

3577 SECTION 121. Notwithstanding any law or regulation to the contrary, the group
3578 insurance commission, office of Medicaid, and the commonwealth connector authority may offer
3579 smart tiered plans, as defined in section 11 of chapter 176J, on January 1, 2014.

3580 SECTION 122. (a) Notwithstanding any general or special law to the contrary, this
3581 section shall facilitate the orderly transfer of the employees, proceedings, rules and regulations,
3582 property and legal obligations of the following functions of state government from the transferor
3583 agencies to the transferee agency, defined as follows: the functions of the health information
3584 technology council and the Massachusetts eHealth Institute, established under section 6D of

3585 chapter 40J, as the transferor agencies, to the division of health care cost and quality established
3586 under section 2 of chapter 118G, as the transferee agency.

3587 (b) The employees of the transferor agencies, including those who were appointed
3588 immediately before the effective date of this act and who hold permanent appointment in
3589 positions classified under chapter 31 of the General Laws or have tenure in their positions as
3590 provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold
3591 confidential positions, are hereby transferred to the transferee agency, without interruption of
3592 service within the meaning of said section 9A of said chapter 31, without impairment of
3593 seniority, retirement or other rights of the employee, and without reduction in compensation or
3594 salary grade, notwithstanding any change in title or duties resulting from such reorganization,
3595 and without loss of accrued rights to holidays, sick leave, vacation and benefits, and without
3596 change in union representation or certified collective bargaining unit as certified by the state
3597 department of labor relations or in local union representation or affiliation. Any collective
3598 bargaining agreement in effect immediately before the transfer date shall continue in effect and
3599 the terms and conditions of employment therein shall continue as if the employees had not been
3600 so transferred. The reorganization shall not impair the civil service status of any such reassigned
3601 employee who immediately before the effective date of this act either holds a permanent
3602 appointment in a position classified under chapter 31 of the General Laws or has tenure in a
3603 position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding any other
3604 general or special law to the contrary, all such employees shall continue to retain their right to
3605 collectively bargain pursuant to chapter 150E of the General Laws and shall be considered
3606 employees for the purposes of said chapter 150E. Nothing in this section shall be construed to
3607 confer upon any employee any right not held immediately before the date of said transfer, or to

3608 prohibit any reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or
3609 abolition of position not prohibited before such date.

3610 (c) All petitions, requests, investigations and other proceedings appropriately and duly
3611 brought before the transferor agencies or duly begun by the transferor agencies and pending
3612 before it before the effective date of this act, shall continue unabated and remain in force, but
3613 shall be assumed and completed by the transferee agency.

3614 (d) All orders, rules and regulations duly made and all approvals duly granted by the
3615 transferor agency, which are in force immediately before the effective date of this act, shall
3616 continue in force and shall thereafter be enforced, until superseded, revised, rescinded or
3617 canceled, in accordance with law, by the transferee agency.

3618 (e) All books, papers, records, documents, equipment, buildings, facilities, funds,
3619 accounts, cash and other property, both personal and real, including all such property held in
3620 trust, which immediately before the effective date of this act are in the custody of the transferor
3621 agencies shall be transferred to the transferee agency.

3622 (f) All duly existing contracts, leases and obligations of the transferor agencies shall
3623 continue in effect but shall be assumed by the transferee agency.

3624 (g) The comptroller shall be authorized to take any actions necessary to support the
3625 transfers outlined in this section. No existing right or remedy of any character shall be lost,
3626 impaired or affected by this act.

3627 SECTION 123. (a) Notwithstanding any general or special law to the contrary, this
3628 section shall facilitate the orderly transfer of the employees, proceedings, rules and regulations,

3629 property and legal obligations of the following functions of state government from the transferor
3630 agencies to the transferee agency, defined as follows: the functions of the division of health care
3631 finance and policy, as the transferor agency, to the division of health care cost and quality, as the
3632 transferee agency.

3633 (b) The employees of the transferor agencies, including those who were appointed
3634 immediately before the effective date of this act and who hold permanent appointment in
3635 positions classified under chapter 31 of the General Laws or have tenure in their positions as
3636 provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold
3637 confidential positions, are hereby transferred to the transferee agency, without interruption of
3638 service within the meaning of said section 9A of said chapter 31, without impairment of
3639 seniority, retirement or other rights of the employee, and without reduction in compensation or
3640 salary grade, notwithstanding any change in title or duties resulting from such reorganization,
3641 and without loss of accrued rights to holidays, sick leave, vacation and benefits, and without
3642 change in union representation or certified collective bargaining unit as certified by the state
3643 department of labor relations or in local union representation or affiliation. Any collective
3644 bargaining agreement in effect immediately before the transfer date shall continue in effect and
3645 the terms and conditions of employment therein shall continue as if the employees had not been
3646 so transferred. The reorganization shall not impair the civil service status of any such reassigned
3647 employee who immediately before the effective date of this act either holds a permanent
3648 appointment in a position classified under chapter 31 of the General Laws or has tenure in a
3649 position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding any other
3650 general or special law to the contrary, all such employees shall continue to retain their right to
3651 collectively bargain pursuant to chapter 150E of the General Laws and shall be considered

3652 employees for the purposes of said chapter 150E. Nothing in this section shall be construed to
3653 confer upon any employee any right not held immediately before the date of said transfer, or to
3654 prohibit any reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or
3655 abolition of position not prohibited before such date.

3656 (c) All petitions, requests, investigations and other proceedings appropriately and duly
3657 brought before the transferor agencies or duly begun by the transferor agencies and pending
3658 before it before the effective date of this act, shall continue unabated and remain in force, but
3659 shall be assumed and completed by the transferee agency.

3660 (d) All orders, rules and regulations duly made and all approvals duly granted by the
3661 transferor agency, which are in force immediately before the effective date of this act, shall
3662 continue in force and shall thereafter be enforced, until superseded, revised, rescinded or
3663 canceled, in accordance with law, by the transferee agency.

3664 (e) All books, papers, records, documents, equipment, buildings, facilities, funds,
3665 accounts, cash and other property, both personal and real, including all such property held in
3666 trust, which immediately before the effective date of this act are in the custody of the transferor
3667 agencies shall be transferred to the transferee agency.

3668 (f) All duly existing contracts, leases and obligations of the transferor agencies shall
3669 continue in effect but shall be assumed by the transferee agency.

3670 (g) The comptroller shall be authorized to take any actions necessary to support the
3671 transfers outlined in this section. No existing right or remedy of any character shall be lost,
3672 impaired or affected by this act.

3673 SECTION 124. Notwithstanding any general or special law to the contrary, the Secretary
3674 of Health and Human Services shall transfer any remaining funds from the Distressed Provider
3675 Expendable Trust Fund, established in Chapter 241 of the Acts of 2004, to the Distressed
3676 Hospital Trust Fund established in Section 2DDDD of chapter 29 of the General Laws..

3677 SECTION 125. There shall be on the books of the commonwealth, an Infrastructure
3678 Improvement Expendable Trust fund. The division shall have control over said trust fund. The
3679 fund shall retain 50% of its total funding for the purposes of improving the commonwealth's
3680 health care infrastructure needs. The other 50% of total funding shall be transferred to the
3681 Distressed Hospital Trust Fund, as created by section 2DDDD of chapter 29.

3682 SECTION 126. Notwithstanding any general or special law to the contrary, the division
3683 of health care cost and quality, established under chapter 118G, shall continue to collect all
3684 assessments formerly collected by the division of health care finance and policy, including,
3685 without limitation, health safety net assessments, nursing home user fees and child immunization
3686 assessments.

3687 SECTION 127. If any provision of this act or its application to any entity, person or
3688 circumstance is held invalid by a court of competent jurisdiction, the invalidity shall not affect
3689 other provisions or applications of this act that can be given effect without the invalid provision
3690 or application, and to this end the provisions of the act are severable.

3691 SECTION 128. Notwithstanding any general or special law to the contrary, all
3692 employees of the division of health care cost and quality established under chapter 118G shall
3693 qualify for participation in the state employees' retirement system established under the
3694 provisions of chapter 32 and state employees' contributory group insurance under chapter 32A.

3695 SECTION 129. Notwithstanding any law or regulation to the contrary, the division of
3696 insurance shall conduct a study on the adequacy of reserves for both payers and providers. The
3697 study shall include the following: (1) current reserves held by payers, (2) current reserves held by
3698 providers, (3) a formula to calculate the minimum necessary reserves for payors based on their
3699 levels of risk, (4) a formula to calculate the minimum necessary reserves for providers based on
3700 their levels of risk, and (5) a threshold of excess reserves. Minimum necessary reserves shall
3701 mean the amount of reserves required for a payer or provider to be fiscally solvent. The threshold
3702 of excess reserves shall represent an amount beyond what a payer or provider should reasonably
3703 hold above the necessary reserves amount. The level of risk shall mean the possible percentages
3704 of risk a provider or payer has in any risk sharing arrangement. Upon completion of this study,
3705 the division shall promulgate all necessary regulations to implement the findings of the study.

3706 The division shall then issue a report on its findings to the senate and house committees
3707 on ways and means and the joint committee on health care financing by July 1, 2013.

3708 SECTION 130. Section 27 of Chapter 141 of the Acts of 2000 is hereby amended by
3709 striking out the phrase “Health Insurance Consumer Protections” and inserting in place thereof
3710 the following phrase:- “Health Care Consumer Protections”.

3711 SECTION 131. Section 1 of Chapter 176O of the General Laws is hereby amended by
3712 inserting before the definition of “Adverse determination” the following definition:-

3713 “Accountable care organization”, an accountable care organization as defined in chapter
3714 118J.

3715 SECTION 132. Section 1 of Chapter 176O of the General Laws is hereby amended by
3716 inserting after the definition of “Emergency medical condition” the following definition:-

3717 “Executive director”, the executive director of the division of health care cost and quality.

3718 SECTION 133. Section 1 of Chapter 176O of the General Laws is hereby amended by
3719 inserting after the definition of “Participating provider” the following definition:-

3720 “Patient centered medial home”, a patient centered medical home as defined in section 45
3721 of 118G.

3722 SECTION 134. Section 1 of Chapter 176O of the General Laws is hereby amended by
3723 inserting after the definition of “Prospective review” the following definition:-

3724 “Physician organization”, a physician organization as defined in section 53H of chapter
3725 111.

3726 SECTION 135. Chapter 176O of the General Laws is hereby amended by inserting at the
3727 end thereof the following 2 sections:-

3728 Section 22. (a) Accountable care organizations, patient centered medical homes, or
3729 physician organizations who receive an alternative payment with shared risk shall create internal
3730 appeals processes. The processes shall be available to the public in both written and available by
3731 request in electronic format.

3732 (b) The internal appeals processes in subsection (a) shall be subject to the following
3733 requirements: (1) timing periods such as (A) internal appeals shall be completed in a period no
3734 longer than 14 days and (B) provided that an expedited internal appeal shall be completed in a
3735 period no longer that 3 days for a patient with a terminal illness; and (2) offer an external opinion
3736 unless it would be impractical for expedited internal appeals.

3737 (c) Accountable care organizations and patient centered medical homes with an approval
3738 from the executive director shall designate a third party as an ombudsman. Said ombudsman
3739 shall act as an advocate for patients. Provided that any patient who elects to have an independent
3740 care coordinator; said care coordinator may act as the patient advocate.

3741 (d) The executive director shall promulgate regulations necessary to implement this
3742 section.

3743 Section 23. (a) Accountable care organizations, patient centered medical homes, or
3744 physician organizations who receive a global payment shall provide an external second opinion.
3745 The external second opinion shall be conducted by a provider who is not a member of the global
3746 payment risk sharing arrangement.

3747 (b) The accountable care organization, patient centered medical home or physician
3748 organization shall be responsible for reimbursing the provider of the second opinion. Said
3749 provider shall receive a rate equal to the in-network contractual rate or if such rate does not exist,
3750 and then the parties shall contract for a rate.

3751 (c) If the provider of the second opinion determines that the denied of service is
3752 medically necessary, then the accountable care organization, patient centered medical home or
3753 physician organization shall provide such services until the office of patient protection rules
3754 otherwise.

3755 SECTION 136. Chapter 12 of the General Laws is hereby amended by inserting at the
3756 end thereof the following section:

3757 Section 33. (a) The Attorney General shall, pursuant to G.L. c. 93A, section 2(c), within
3758 180 days of the enactment of this section, investigate and issue regulations proscribing unfair,
3759 deceptive, or anticompetitive conduct within the Commonwealth's healthcare marketplace. Such
3760 regulations shall include, at a minimum, the prohibition of anticompetitive contracting practices
3761 between and/or among acute care hospitals and insurers, in which the acute care hospital
3762 possesses the market power to impose non-transitory increases in rates charged for health care
3763 services.

3764 (b) The following shall be unfair methods of competition and unfair or deceptive acts or
3765 practices for providers or provider organizations: (i) entering into any agreement to commit or
3766 by any concerted action committing any act of boycott, coercion, or intimidation resulting in or
3767 tending to result in unreasonable restraint of or monopoly in the delivery of health care services,
3768 contracting for payment for health care services, or the business of insurance; (ii) seeking to set
3769 the price to be paid by any carrier for network contracts at rates that are excessive, unreasonable,
3770 discriminatory, predatory, or would otherwise cause the carrier to violate the requirements of its
3771 licensure or accreditation; (iii) engaging in any unfair discrimination between individuals who
3772 are similarly covered by network contracts; and (iv) making, publishing, disseminating,
3773 circulating, or placing before the public, directly or indirectly, any assertion, representation or
3774 statement which is untrue, deceptive or misleading.

3775 SECTION 137. Chapter 118E of the General Laws is hereby amended by inserting after
3776 section 9E the following section:-

3777 Section 9F. (a) As used in this section, the follow words shall have the following
3778 meanings:-

3779 “Dual eligible”, or “dually eligible person”, any person age 21 or older and under age 65
3780 who is enrolled in both Medicare and either MassHealth or CommonHealth; provided that the
3781 executive office may include within the definition of dual eligible any person enrolled in
3782 MassHealth or CommonHealth who also receives benefits under Title II of the Social Security
3783 Act on the basis of disability and will be eligible for Medicare within 24 months, provided that
3784 the executive office may limit eligibility to those who will be eligible for Medicare within a
3785 prescribed number of months that is less than 24.

3786 “Integrated care organization” or “ICO”, a comprehensive network of medical, health
3787 care and long term services and supports providers that integrates all components of care, either
3788 directly or through subcontracts and has been contracted with by the Executive Office of Health
3789 and Human Services and designated an ICO to provide services to dually eligible individuals
3790 pursuant to this section.

3791 (b) Members of the MassHealth dual eligible pilot program on ICOs or any successor
3792 program integrating care for dual eligible persons shall initially be provided an independent
3793 community care coordinator by the ICO or successor organization, who shall be a participant in
3794 the member’s care team. The member may direct the withdrawal or reinstatement of the
3795 independent care coordinator at any time. The community care coordinator shall assist in the
3796 development of a long term support and services care plan. The community care coordinator
3797 shall:

3798 (1) participate in initial and ongoing assessments of the health and functional status of the
3799 member, including determining appropriateness for long term care support and services, either in

3800 the form of institutional or community-based care plans and related service packages necessary
3801 to improve or maintain enrollee health and functional status;

3802 (2) arrange and, with the agreement of the care team, coordinate and authorize the
3803 provision of appropriate institutional and community long term care and supports and services,
3804 including assistance with the activities of daily living and instrumental activities of daily living,
3805 housing, home-delivered meals, transportation, and under specific conditions or circumstances
3806 established by the ICO or successor organization, authorize a range and amount of community-
3807 based services; and

3808 (3) monitor the appropriate provision and functional outcomes of community long term
3809 care services, according to the service plan as deemed appropriate by the care team; and

3810 track member satisfaction and the appropriate provision and functional outcomes of
3811 community long term care services, according to the service plan as deemed appropriate by the
3812 care team.

3813 (c) The ICO or successor organization shall not have a direct or indirect financial
3814 ownership interest in an entity that serves as an independent care coordinator. Providers of
3815 institutional or community based long term services and supports on a compensated basis shall
3816 not function as an independent care coordinator, provided however that the secretary may grant a
3817 waiver of this restriction upon a finding that public necessity and convenience require such a
3818 waiver. In the case of a member in the program age 60 or older, the member shall be offered the
3819 option of the services of an independent care coordinator as designated by the executive office of
3820 elder affairs pursuant to the provisions of section 4B of chapter 19 A. For purposes of this
3821 section, an organization compensated to provide only evaluation, assessment, coordination and

3822 fiscal intermediary services shall not be considered a provider of long term services and
3823 supports.

3824 SECTION 138. Notwithstanding any law or rule the contrary, the health care workforce
3825 center shall investigate the possibility of dedicating funds for joint appointments for clinicians
3826 with clinical agencies and universities. As part of the arrangement, clinicians pursuing doctoral
3827 education would receive tuition and fee reimbursement for maintaining a clinical position and
3828 teaching at the entry level of the academic program while pursuing their doctoral degree.

3829 SECTION 139. Section 21 shall take effect on January 1, 2015.

3830 SECTION 140. Section 74 shall take effect on January 1, 2017.