

SENATE No. 2270

Senate, May 17, 2012 – Text of the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (being the text of Senate, No. 2260, printed as amended).

The Commonwealth of Massachusetts

—————
In the Year Two Thousand Twelve
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An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation..

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. Section 38C of chapter 3 of the General Laws, as appearing in the 2010
2 Official Edition, is hereby amended by striking out, in lines 25, 29, 32, 35, 37, 39, 40, 44 and 45,
3 47, 48, 54, 86, 89 and 93, the word “division” and inserting in place thereof, in each instance,
4 the following word:- institute.

5 SECTION 2. Subsection (d) of said section 38C of said chapter 3, as so appearing, is
6 hereby amended by striking out, in line 43, the words “, the health care quality and cost
7 council,”.

8 SECTION 3. Section 105 of chapter 6 of the General Laws , as amended by section 9 of
9 chapter 3 of the acts of 2011, is hereby further amended by striking out the words “commissioner
10 of health care finance and policy” and inserting in place thereof the following words:- executive
11 director of the institute of health care finance and policy.

12 SECTION 4. Section 16 of chapter 6A of the General Laws, as appearing in the 2010
13 Official Edition, is hereby amended by striking out, in line 52, the words “pursuant to section 2A
14 of chapter 118G” and inserting in place thereof the following words:- under section 13C of
15 chapter 118E.

16 SECTION 5. Sections 16J to 16L, inclusive, of said chapter 6A of the General Laws are
17 hereby repealed.

18 SECTION 6. Section 16M of said chapter 6A, as appearing in the 2010 Official Edition,
19 is hereby amended by striking out, in lines 3 and 4, the words “commissioner of health care
20 financing” and inserting in place thereof the following words:- executive director of the institute
21 of health care finance.

22 SECTION 7. Section 16M of said chapter 6A, as so appearing, is hereby further amended
23 by striking out, in lines 23, 32, 39 and 43 the word “division” and inserting in place thereof, in
24 each instance, the following word:- institute.

25 SECTION 8. Said section 16M of said chapter 6A, as so appearing, is hereby further
26 amended by striking out, in line 24, the word “118G” and inserting in place thereof the following
27 word:- 12C.

28 SECTION 9. Section 16N of said chapter 6A, as so appearing, is hereby amended by
29 striking out, in lines 5 and 6, the words “commissioner of health care finance and policy” and
30 inserting in place thereof the following words:- executive director of the institute of health care
31 finance and policy.

32 SECTION 10. Subsection (a) of section 16O of said chapter 6A, as so appearing, is
33 hereby amended by striking out the fifth sentence.

34 SECTION 11. The third sentence of subsection (c) of section 4R of chapter 7 of the
35 General Laws, as inserted by section 15 of chapter 68 of the acts of 2011, is hereby amended by
36 striking out the word “division” and inserting in place thereof the following word:- institute.

37 SECTION 12. Section 22N of said chapter 7, as appearing in the 2010 Official Edition, is
38 hereby amended by striking out, in lines 10 and 37, the word “118G” and inserting in place
39 thereof, in each instance, the following word:- 118E.

40 SECTION 13. Chapter 12 of the General Laws is hereby amended by inserting after
41 section 11M the following section:-

42 Section 11N. (a) The attorney general shall monitor trends in the health care market
43 including, but not limited to, trends in provider organization size and composition, consolidation
44 in the provider market, payer contracting trends and patient access and quality issues in the
45 health care market. The attorney general may obtain the following information from a private
46 health care payer, public health care payer, provider or provider organization, as those terms are
47 defined in section 1 of chapter 12C: (i) any information that is required to be submitted under
48 sections 9, 10 and 11 of chapter 12C, (ii) filings, applications and supporting documentation
49 related to any material change subject to a cost, market impact and solvency review under
50 section 10 of chapter 12C and (iii) filings, applications and supporting documentation related to a
51 determination of need application filed under section 25C of chapter 111. Under section 15 of
52 chapter 12C and section 6 of chapter 176S, and subject to the limitations stated in those sections,
53 the attorney general may require that any provider, provider organization, private health care

54 payer or public health care payer produce documents, answer interrogatories and provide
55 testimony under oath related to health care costs and cost trends , the factors that contribute to
56 cost growth within the commonwealth’s health care system and the relationship between
57 provider costs and payer premium rates.

58 (b) The attorney general shall, in consultation with the institute of health care finance and
59 policy, take appropriate action within existing statutory authority to: (i)prevent excess
60 consolidation or collusion of provider organizations and to remedy these or other related anti-
61 competitive dynamics in the health care market; (ii) prevent unreasonable increases in health
62 care rates, charges, medical expenses or prices; and (iii) prevent or mitigate adverse effects on
63 patient access and quality in the health care market.

64 (c) The attorney general may intervene or otherwise participate in efforts by the
65 commonwealth to obtain exemptions or waivers from certain federal laws regarding provider
66 market conduct, including, from the federal Office of the Inspector General, a waiver of, or
67 expansion of, the “safe harbors” provided for under 42 U.S.C. section 1320a-7b and obtaining
68 from the federal Office of the Inspector General a waiver of, or exemption from, 42 U.S.C.
69 section 1395nn subsections (a) to (e).

70 (d) The attorney general may act under existing authority including, but not limited to,
71 subsection (b) of section 15 of chapter 12C and section 6 of chapter 176S to carry out this
72 section.

73 SECTION 14. The General Laws are hereby further amended by inserting after chapter
74 12B the following chapter:-

75 Chapter 12C

76

Institute of Health Care Finance and Policy

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Section 1. As used in this chapter the following words shall, unless the context clearly

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requires otherwise, have the following meanings:-

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“Actual costs”, all direct and indirect costs incurred by a hospital or a community health

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center in providing medically necessary care and treatment to its patients, determined in

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accordance with generally accepted accounting principles.

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“Acute hospital”, the teaching hospital of the University of Massachusetts Medical

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School and any hospital licensed under section 51 of chapter 111 and which contains a majority

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of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of

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public health.

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“Alternative payment contract”, any contract between a provider or provider organization

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and a public health care payer or a private health care payer which utilizes alternative payment

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methodologies.

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“Alternative payment methodologies”, methods of payment that are not fee-for-service

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reimbursements; provided that, “alternative payment methodologies” may include, but not be

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limited to, global payments, shared savings arrangements, bundled payments and episodic

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payments.

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“Ambulatory surgical center”, any distinct entity that operates exclusively to provide

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surgical services to patients not requiring hospitalization and meets the requirements of the

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

96 “Ambulatory surgical center services”, services described for purposes of the Medicare
97 program under 42 USC § 1395k(a)(2)(F)(I); provided, that “ambulatory surgical center services”
98 shall include facility services only and shall not include surgical procedures.

99 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health
100 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
101 176A; a nonprofit medical service corporation organized under chapter 176B; a health
102 maintenance organization organized under chapter 176G; and an organization entering into a
103 preferred provider arrangement under chapter 176I, but not including an employer purchasing
104 coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or
105 affiliated corporations of the employer; provided that, unless otherwise noted, the term “carrier”
106 shall not include any entity to the extent it offers a policy, certificate or contract that provides
107 coverage solely for dental care services or visions care services.

108 “Case mix”, the description and categorization of a hospital’s patient population
109 according to criteria approved by the institute including, but not limited to, primary and
110 secondary diagnoses, primary and secondary procedures, illness severity, patient age and source
111 of payment.

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

113 “Child”, a person who is under 18 years of age.

114 “Clinical affiliation,” any relationship between a provider organization and another entity
115 for the purpose of increasing the level of collaboration in the provision of health care services,
116 including but not limited to sharing of physician resources in hospital or other ambulatory
117 settings, co-branding, expedited transfers to advanced care settings, provision of inpatient

118 consultation coverage or call coverage, enhanced electronic access and communication, co-
119 located services, provision of capital for service site development, joint training programs, video
120 technology to increase access to expert resources and sharing of hospitalists or intensivists.

121 “Community health centers”, health centers operating in conformance with Section 330
122 of United States Public Law 95-626 and shall include all community health centers which file
123 cost reports as requested by the institute.

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

127 “Dispersed service area,” a geographic area of the commonwealth in which a provider
128 organization delivers health care services; provided, however, that the institute may by regulation
129 establish standards to determine dispersed service areas based on the number of zip codes, towns,
130 counties or primary service areas, which standards may vary based upon the population density
131 of various regions of the commonwealth.

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

135 “Employee”, a person who performs services primarily in the commonwealth for
136 remuneration for a commonwealth employer; provided, that “employee” shall not include a
137 person who is self-employed.

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

139 “Executive director”, the executive director of the institute of health care finance and
140 policy.

141 “Facility”, a licensed institution providing health care services or a health care setting,
142 including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical
143 or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory
144 and imaging centers, and rehabilitation and other therapeutic health settings.

145 "Fee-for-service", a form of contract under which a provider or provider organization is
146 paid for discrete and separate units of service and each provider is separately reimbursed for each
147 discrete service rendered to a patient; provided, however, that up to 20 per cent of total
148 reimbursement under such contracts may depend on the achievement of certain targets of
149 performance or conduct.

150 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
151 ends in the calendar year by which it is identified.

152 “General health supplies, care or rehabilitative services and accommodations”, all
153 supplies, care and services of medical, behavioral health, substance use disorder, mental health,
154 optometric, dental, surgical, chiropractic, podiatric, psychiatric, therapeutic, diagnostic,
155 rehabilitative, supportive or geriatric nature, including inpatient and outpatient hospital care and
156 services, and accommodations in hospitals, sanatoria, infirmaries, convalescent and nursing
157 homes, retirement homes, facilities established, licensed or approved under chapter 111B and
158 providing services of a medical or health-related nature, and similar institutions including those
159 providing treatment, training, instruction and care of children and adults; provided, however, that

160 rehabilitative service shall include only rehabilitative services of a medical or health-related
161 nature which are eligible for reimbursement under Title XIX of the Social Security Act.

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

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

166 “Health care professional,” a physician or other health care practitioner licensed,
167 accredited, or certified to perform specified health services consistent with law.

168 “Health care services”, supplies, care and services of medical, behavioral health,
169 substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic,
170 psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature
171 including, but not limited to, inpatient and outpatient acute hospital care and services; services
172 provided by a community health center or by a sanatorium, as included in the definition of
173 “hospital” in Title XVIII of the federal Social Security Act, and treatment and care compatible
174 with such services or by a health maintenance organization.

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

177 “Health insurance plan”, the medicare program or an individual or group contract or other
178 plan providing coverage of health care services and which is issued by a health insurance
179 company, a hospital service corporation, a medical service corporation or a health maintenance
180 organization.

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

184 “Health status adjusted total medical expenses”, the total cost of care for the patient
185 population associated with a provider group based on allowed claims for all categories of
186 medical expenses and all non-claims related payments to providers, adjusted by health status,
187 and expressed on a per member per month basis, as calculated under section 9 and the
188 regulations promulgated by the institute.

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

192 “Hospital service corporation”, a corporation established to operate a nonprofit hospital
193 service plan as provided in chapter 176A.

194 “Institute”, the institute of health care finance and policy.

195 “Major service category,” a set of service categories to be established by regulation,
196 which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii)
197 outpatient and ambulatory services, by categories as defined by the Centers for Medicare and
198 Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all
199 other” outpatient and ambulatory services that do not fall within a defined category; (iii)
200 behavioral, substance use disorder and mental health services by categories as defined by the
201 Centers for Medicare and Medicaid, or as established by regulation; (iv) professional services, by

202 categories as defined by the Centers for Medicare and Medicaid, or as established by regulation;
203 and (v) sub-acute services, by major service line or clinical offering, as defined by regulation.

204 “Medicaid program”, the medical assistance program administered by the division of
205 medical assistance under chapter 118E and in accordance with Title XIX of the Federal Social
206 Security Act or any successor statute.

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

210 “Medical service corporation”, a corporation established to operate a nonprofit medical
211 service plan as provided in chapter 176B.

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

214 “Net cost of private health insurance,” the difference between health premiums earned
215 and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as
216 included in medical loss ratio regulations promulgated by the division of insurance; (ii) net
217 additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise
218 defined by regulations promulgate by the institute.

219 “Network contract,” a contract entered between a provider or provider organization and a
220 carrier or third-party administrator concerning payment for the provision of health care services.

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

222 “Patient”, any natural person receiving health care services.

223 "Primary service area," a geographic area of the commonwealth in which consumers are
224 likely to travel to obtain health services, provided however that the institute may by regulation
225 establish standards to determine primary service areas by major service category, which
226 standards may vary based upon the population density of various regions of the commonwealth.

227 "Private health care payer", a carrier authorized to transact accident and health insurance
228 under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a
229 nonprofit medical service corporation licensed under chapter 176B, a dental service corporation
230 organized under chapter 176E, an optometric service corporation organized under chapter 176F,
231 a self-insured plan, to the extent allowable under federal law governing health care provided by
232 employers to employees, or a health maintenance organization licensed under chapter 176G.

233 "Provider", any person, corporation partnership, governmental unit, state institution or
234 any other entity qualified under the laws of the commonwealth to perform or provide health care
235 services.

236 "Provider organization," any corporation, partnership, business trust, association or
237 organized group of persons whether incorporated or not that consists of or represents 1 or more
238 providers in contracting with carriers for the payments the provider or providers receive for the
239 provision of health care services or as defined in regulations promulgated by the institute;
240 provided, that "provider organization" shall include, but not be limited to, physician
241 organizations, physician-hospital organizations, independent practice associations, provider
242 networks, accountable care organizations and any other organization that contracts with carriers
243 for payment for health care services.

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

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

254 “Registered provider organization,” a provider organization that has been registered in
255 accordance with this chapter and regulations promulgated under this chapter.

256 “Relative prices”, the contractually negotiated amounts paid to providers by each private
257 and public carrier for health care services, including non-claims related payments and expressed
258 in the aggregate relative to the payer’s network-wide average amount paid to providers, as
259 calculated under section 9 and regulations promulgated by the institute.

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

262 “Resident”, a person living in the commonwealth, as defined by the institute by
263 regulation; provided, however, that such regulation shall not define a resident as a person who
264 moved into the commonwealth for the sole purpose of securing health insurance under this

265 chapter; and provided, further that confinement of a person in a nursing home, hospital or other
266 medical institution shall not in and of itself, suffice to qualify such person as a resident.

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

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

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

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

279 “Surcharge payor”, an individual or entity that pays for or arranges for the purchase of
280 health care services provided by acute hospitals and ambulatory surgical center services provided
281 by ambulatory surgical centers; provided, however, that the term “surcharge payor” shall include
282 a managed care organization; and provided further, that “surcharge payor” shall not include Title
283 XVIII and Title XIX programs and their beneficiaries or recipients, other governmental
284 programs of public assistance and their beneficiaries or recipients and the workers’ compensation
285 program established under chapter 152.

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

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

293 “Total health care expenditures”, the annual per capita sum of all health care expenditures
294 in the commonwealth from public and private sources, including: (i) all categories of medical
295 expenses and all non-claims related payments to providers, as included in the health status
296 adjusted total medical expenses reported by the institute under subsection (d) of section 9; (ii) all
297 patient cost-sharing amounts, such as, deductibles and copayments; and (iv) the net cost of
298 private health insurance, or as otherwise defined in regulations promulgated by the institute.

299 Section 2. There is hereby established an institute of health care finance and policy. There
300 shall be in the institute an executive director, who shall be the administrative head of the institute
301 and who shall be appointed by a majority vote of the attorney general, the state auditor and the
302 governor for a term of 5 years. The person so appointed shall be selected without regard to
303 political affiliation and solely on the basis of expertise in health care policy, expertise in health
304 care finance and such other educational requirements and experience that the attorney general,
305 state auditor and governor determine are necessary.

306 In the case of a vacancy in the position of executive director a successor shall be
307 appointed in the same manner as the original appointment for the unexpired term. No person
308 shall be appointed for more than 2 consecutive 5-year terms.

309 The person so appointed may be removed from office, for cause, by a majority vote of the
310 attorney general, the state auditor and the governor. Such cause may include substantial neglect
311 of duty, gross misconduct or conviction of a crime. The reasons for removal of the executive
312 director shall be stated in writing and shall include the basis for such removal. The writing shall
313 be sent to the clerk of the senate, the clerk of the house of representative and to the governor at
314 the time of the removal and shall be a public document.

315 Section 3. There shall be an institute of health care finance and policy council. The
316 council shall advise on the overall operation and policy of the institute. The council shall be
317 chosen by the executive director and shall reflect a broad distribution of diverse perspectives on
318 the health care system, including health care professionals, educational institutions, consumer
319 representatives, medical device manufacturers, representatives of the biotechnology industry,
320 pharmaceutical manufacturers, providers, provider organizations, labor organizations and public
321 and private payers

322 Section 4. The executive director may appoint and remove, subject to appropriation, such
323 agents and subordinate officers as the executive director may consider necessary and may
324 establish such subdivisions within the institute as the executive director considers appropriate to
325 fulfill the following duties: (i) to collect, analyze and disseminate health care data to assist in the
326 formulation of health care policy and in the provision and purchase of health care services
327 including, but not limited to, collecting, storing and maintaining data in a payer and provider

328 claims database; (ii) to provide an analysis of health care spending trends as compared to the
329 health care cost growth benchmark established by the health care quality and finance authority
330 under section 5 of chapter 176S; (iii) to develop and administer a registration system for provider
331 organizations and collect, analyze and disseminate information regarding provider organizations
332 to increase the transparency and improve the functioning of the health care system; (iv) to
333 provide information to, and work with, the general court and other state agencies including, but
334 not limited to, the executive office of health and human services, the department of public health,
335 the department of mental health, the health care quality and finance authority, the office of
336 Medicaid and the division of insurance to collect and disseminate data concerning the cost, price
337 and functioning of the health care system in the commonwealth and the health status of
338 individuals; (v) to participate in and provide data and data analysis for annual hearings conducted
339 by the health care quality and finance authority concerning health care provider and payer costs,
340 prices and cost trends; and (vi) report to consumers comparative health care cost and quality
341 information through the consumer health information website established under section 20. The
342 institute shall make available actual costs and prices of health care services, as supplied by each
343 provider, to the general public in a conspicuous manner on the institute's official website.

344 Section 5. The position of executive director shall be classified under section 45 of
345 chapter 30 and the salary shall be determined under section 46C of said chapter 30.

346 Section 6. The institute shall adopt and amend rules and regulations, in accordance with
347 chapter 30A, for the administration of its duties and powers and to effectuate this chapter. Such
348 regulations shall be adopted, after notice and hearing, only upon consultation with
349 representatives of providers, provider organizations, private health care payers and public health
350 care payers.

351 Section 7. In addition to the powers conferred on state agencies, the institute shall have
352 the following powers:—

353 (a) to make, amend and repeal rules and regulations for the management of its affairs;

354 (b) to make contracts and execute all instruments necessary or convenient for the carrying
355 on of its business;

356 (c) to acquire, own, hold, dispose of and encumber personal property and to lease real
357 property in the exercise of its powers and the performance of its duties; and

358 (d) to enter into agreements or transactions with any federal, state or municipal agency or
359 other public institution or with any private individual, partnership, firm, corporation, association
360 or other entity.

361 Section 8. Each acute hospital and surcharge payor shall pay to the commonwealth an
362 amount for the estimated expenses of the institute.

363 The assessed amount for hospitals shall be not less than 33 per cent of the amount
364 appropriated by the general court for the expenses of the institute minus amounts collected from
365 (1) filing fees; (2) fees and charges generated by the institute's publication or dissemination of
366 reports and information; and (3) federal matching revenues received for these expenses or
367 received retroactively for expenses of predecessor agencies. Each acute hospital shall pay such
368 assessed amount multiplied by the ratio of the hospital's gross patient service revenues to the
369 total of all such hospital's gross patient services revenues. Each acute hospital shall make a
370 preliminary payment to the institute on October 1 of each year in an amount equal to ½ of the
371 previous year's total assessment. Thereafter, each hospital shall pay, within 30 days notice from

372 the institute, the balance of the total assessment for the current year based upon its most current
373 projected gross patient service revenue. The institute shall subsequently adjust the assessment for
374 any variation in actual and estimated expenses of the institute and for changes in hospital gross
375 patient service revenue. Such estimated and actual expenses shall include an amount equal to the
376 cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D
377 of chapter 29. In the event of late payment by any such hospital, the treasurer shall advance the
378 amount of due and unpaid funds to the institute prior to the receipt of such monies in anticipation
379 of such revenues up to the amount authorized in the then current budget attributable to such
380 assessments and the institute shall reimburse the treasurer for such advances upon receipt of such
381 revenues. This section shall not apply to any state institution or to any acute hospital which is
382 operated by a city or town.

383 The assessed amount for surcharge payors shall be not less than 33 per cent of the amount
384 appropriated by the general court for the expenses of the institute minus amounts collected from
385 (1) filing fees; (2) fees and charges generated by the institute's publication or dissemination of
386 reports and information; and (3) federal matching revenues received for these expenses or
387 received retroactively for expenses of predecessor agencies. The assessment on surcharge
388 payors shall be calculated and collected in the same manner as the assessment authorized under
389 section 68 of chapter 118E.

390 Section 9. (a) The institute shall promulgate regulations to require providers to report
391 such data as necessary to identify, on a patient-centered and provider-specific basis, statewide
392 and regional trends in the cost, price, availability and utilization of medical, surgical, diagnostic
393 and ancillary services provided by acute hospitals, nursing homes, chronic care and rehabilitation
394 hospitals, other specialty hospitals, clinics, including mental health clinics and such ambulatory

395 care providers as the institute may specify. Such regulations shall ensure uniform reporting of
396 revenues, charges, prices, costs and utilization of health care services delivered by institutional
397 and non-institutional providers and, relative to acute care hospitals, uniform reporting of hospital
398 inpatient and outpatient costs, including direct and indirect costs. The institute shall also
399 promulgate regulations to require providers to report any agreements through which 1 provider
400 agrees to furnish another provider with a discount, rebate or any other type of refund or
401 remuneration in exchange for, or in any way related to, the provision of health care services.

402 (b) With respect to any acute or non-acute hospital, the institute shall, by regulation,
403 designate information necessary to effectuate this chapter including, but not be limited to, the
404 filing of a charge book, the filing of cost data and audited financial statements and the
405 submission of merged billing and discharge data. The institute shall, by regulation, designate
406 standard systems for determining, reporting and auditing volume, case-mix, proportion of low-
407 income patients and any other information necessary to effectuate this chapter and to prepare
408 reports comparing acute and non-acute care hospitals by cost, utilization and outcome. Such
409 regulations may require such hospitals to file required information and data by electronic means;
410 provided, however, that the institute shall allow reasonable waivers from such requirement. The
411 institute shall, at least annually, publish a report analyzing such comparative information to assist
412 third-party payers and other purchasers of health services in making informed decisions. Such
413 report shall include comparative price and service information relative to outpatient mental
414 health services.

415 (c) The institute shall also collect and analyze such data as it considers necessary in order
416 to better protect the public's interest in monitoring the financial conditions of acute hospitals.
417 Such information shall be analyzed on an industry-wide and hospital-specific basis and shall

418 include, but not be limited to: (i) gross and net patient service revenues; (ii) sources of hospital
419 revenue, including revenue excluded from consideration in the establishment of hospital rates
420 and charges under section 13G of chapter 118E; (iii) private sector charges; (iv) trends in
421 inpatient and outpatient case mix, payer mix, hospital volume and length of stay; and (v) other
422 relevant measures of financial health or distress.

423 The institute shall publish annual reports and establish a continuing program of
424 investigation and study of financial trends in the acute hospital industry, including an analysis of
425 systemic instabilities or inefficiencies that contribute to financial distress in the acute hospital
426 industry. Such reports shall include an identification and examination of hospitals that the
427 institute considers to be in financial distress, including any hospitals at risk of closing or
428 discontinuing essential health services, as defined by the department of public health under
429 section 51G of chapter 111, as a result of financial distress.

430 The institute may modify uniform reporting requirements established under subsections
431 (a) and (b) and may require hospitals to report required information quarterly to effectuate this
432 subsection.

433 (d) The institute shall publicly report and place on its website information on health status
434 adjusted total medical expenses including a breakdown of such health status adjusted total
435 medical expenses by major service category and by payment methodology, relative prices and
436 hospital inpatient and outpatient costs, including direct and indirect costs under this chapter on
437 an annual basis; provided, however, that at least 10 days prior to the public posting or reporting
438 of provider specific information the affected provider shall be provided the information for

439 review. The institute shall request from the federal Centers for Medicare and Medicaid Services
440 the health status adjusted total medical expenses of provider groups that serve Medicare patients.

441 (e) When collecting information or compiling reports intended to compare individual
442 health care providers, the institute shall require that:

443 (1) providers which are representative of the target group for profiling shall be
444 meaningfully involved in the development of all aspects of the profile methodology, including
445 collection methods, formatting and methods and means for release and dissemination;

446 (2) the entire methodology for collecting and analyzing the data shall be disclosed
447 to all relevant provider organizations and to all providers under review;

448 (3) data collection and analytical methodologies shall be used that meet accepted
449 standards of validity and reliability;

450 (4) the limitations of the data sources and analytic methodologies used to develop
451 provider profiles shall be clearly identified and acknowledged, including, but not limited to, the
452 appropriate and inappropriate uses of the data;

453 (5) to the greatest extent possible, provider profiling initiatives shall use standard-
454 based norms derived from widely accepted, provider-developed practice guidelines;

455 (6) provider profiles and other information that have been compiled regarding
456 provider performance shall be shared with providers under review prior to dissemination;
457 provided, however, that opportunity for corrections and additions of helpful explanatory
458 comments shall be provided prior to publication; and, provided, further, that such profiles shall

459 only include data which reflect care under the control of the provider for whom such profile is
460 prepared;

461 (7) comparisons among provider profiles shall adjust for patient case-mix and
462 other relevant risk factors and control for provider peer groups, when appropriate;

463 (8) effective safeguards to protect against the unauthorized use or disclosure of
464 provider profiles shall be developed and implemented;

465 (9) effective safeguards to protect against the dissemination of inconsistent,
466 incomplete, invalid, inaccurate or subjective profile data shall be developed and implemented;
467 and

468 (10) the quality and accuracy of provider profiles, data sources and methodologies
469 shall be evaluated regularly.

470 Section 10. (a) The institute shall develop and administer a registration program for
471 provider organizations and shall collect and analyze such data as it considers necessary in order
472 to better protect the public's interest in monitoring the financial conditions, organizational
473 structure, market power and business practices of provider organizations. The institute may
474 assess a registration or administrative fee on provider organizations in such amount to help
475 defray the institute's costs in complying with this section. The institute shall promulgate such
476 regulations as may be necessary to ensure the uniform reporting of data collected under this
477 section. The institute may specify in regulations such uniform reporting thresholds as it
478 determines necessary. Such uniform reporting shall, at a minimum, enable the institute to identify
479 and analyze: (i) the organizational structure of each provider organization, including parent
480 entities, clinical affiliates and corporate affiliates as applicable; (ii) the financial condition and

481 solvency of each provider organization and ability to manage any alternative payment contracts
482 that it has entered into; and (iii) market share by provider organization by primary service areas,
483 dispersed service areas and the categories of services provided.

484 (b) The institute shall establish by regulation at least 5 levels of registration requirements
485 and standards for provider organizations which vary based on factors including degree of
486 provider integration, operational size, annual net patient service revenue, related business
487 activities including insurance and the extent to which the provider organization accepts
488 alternative payment methodologies. One level of registration requirements and standards shall be
489 applicable to provider organizations certified as Beacon ACOs by the health care quality and
490 finance authority. One level of standards and registration requirements shall be designed for
491 provider organizations that do not accept risk payments. For each level, the institute shall
492 establish minimum registration and public reporting requirements on consumer protections and
493 quality benchmarks.

494 (c) The institute shall require, at a minimum, that all provider organizations provide: (i)
495 organizational charts showing the ownership, governance and operational structure of the
496 provider organization, including any clinical affiliations and community advisory boards; (ii) the
497 number of affiliated health care professional full-time equivalents by license type, specialty,
498 name and address of principal practice location and whether the professional is employed by the
499 organization; (iii) the name and address of licensed facilities by license number, license type and
500 capacity in each major service category; (iv) a comprehensive financial statement, including
501 information on parent entities and corporate affiliates as applicable, and including details
502 regarding annual costs, annual receipts, realized capital gains and losses, accumulated surplus
503 and accumulated reserves; (v) Information on stop-loss insurance and any non-fee-for-service

504 payment arrangements; (vi) information on clinical quality, care coordination and patient referral
505 practices; (vii) information regarding expenditures and funding sources for payroll, teaching,
506 research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions; (viii)
507 information regarding charitable care and community benefit programs; (ix) for any provider
508 organization which enters alternative payment contracts, a certification under subsection (e); and
509 (x) such other information as the institute considers appropriate.

510 (d) Each registered provider organization shall annually file with the institute a
511 comprehensive financial statement showing the organization's financial condition for the prior
512 year, including information on parent entities and corporate affiliates as applicable and such
513 other information as the institute may require by regulation, such as organizational or clinical
514 information. Annual reporting shall be in a form provided by the institute and shall include, at a
515 minimum, sufficient information to demonstrate the solvency of the provider organization and
516 its ability to manage any alternative payment contracts into which it has entered. Any provider
517 organization which enters or renews alternative payment contracts shall provide, with the
518 provider organization's annual report, a certification under subsection (e). The institute may
519 require in writing, at any time, such additional information as is reasonable and necessary to
520 determine the financial condition of a registered provider organization.

521 (e) The institute shall, in collaboration with the division of insurance, establish by
522 regulation a certification process for any provider organization which enters into alternative
523 payment contracts. Such certification process shall be designed to determine whether a provider
524 organization has adequate reserves and other measures of financial solvency to meet its risk
525 arrangements. The standards for such certification may vary based on the provider organization
526 size, the type of alternative payment methodology employed, the amount and type of risk

527 assumed and such other criteria as the commissioner of insurance considers appropriate to ensure
528 that provider organizations do not assume excess risk. The institute, in collaboration with the
529 division of insurance, shall establish a schedule to renew such certification; provided, that such
530 certification be renewed at least annually.

531 (f) In developing standards, registration and reporting requirements, the institute shall
532 consider other rules and regulations applicable to such organizations, shall consult with the
533 division of insurance regarding standards concerning risk-bearing by providers and provider
534 organizations and shall consult with the health care quality and finance authority regarding
535 standards concerning provider organizations which enter into alternative payment contracts.

536 (g) Every provider organization shall, before making any change to its operations or
537 governance structure affecting the provider organization's registration, submit notice to the
538 institute and the attorney general of such change. The institute may promulgate regulations
539 prescribing the contents of any notices required to be filed under this section. The institute may
540 promulgate regulations further defining material change and not material change.

541 If the change is not material, the notice shall be filed not fewer than 15 days before the
542 date of the change. A change that is not material may proceed on the date identified in the notice
543 once the notice has been accepted by the institute. Changes that are not material, for purposes of
544 this section, shall include, at a minimum, changes in board membership except when such
545 changes are related to a corporate affiliation, changes involving employment decisions by the
546 provider organization, changes that are subject to review by a state agency through any other
547 administrative process and changes that are necessary to comply with state or federal law. The

548 institute may promulgate regulations defining additional categories of changes that it shall
549 consider not material.

550 If the change is material, the notice shall be filed not fewer than 60 days before the date
551 of the proposed change. Within 30 days of receipt of a notice filed under the institute's
552 regulations, the institute shall conduct a preliminary review to determine whether the change is
553 likely to result in a significant impact on the commonwealth's ability to meet the health care cost
554 growth benchmark, established in section 5 of chapter 176S, on the competitive market or on a
555 provider organization's solvency. The institute shall notify the attorney general that it is
556 conducting a preliminary review. Material changes that are likely to result in a significant
557 impact shall include, but not be limited to: a corporate affiliation between a provider
558 organization and a carrier; mergers or acquisitions of hospitals or hospital systems; acquisition of
559 insolvent provider organizations; and mergers or acquisitions of provider organizations which
560 will result in a provider organization having a near-majority of market share in a given service or
561 region. The institute shall specify, through regulations, other categories of material changes
562 likely to result in significant impact. The institute may require supplementary submissions from
563 the provider organization to provide data necessary to carry out this preliminary review. A
564 provider organization's supplementary submissions shall be confidential and shall not be
565 considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 until
566 the issuance of the institute's report on its findings as a result of the preliminary review.

567 If the institute finds that the material change is unlikely to have a significant impact on
568 the commonwealth's ability to meet the health care cost growth benchmark, established in
569 section 5 of chapter 176S, on the competitive market or on the provider organization's solvency,
570 then the institute shall notify the provider organization of the outcome of its preliminary review

571 and the material change may proceed on the date identified in the notice. If the institute finds
572 that the material change is likely to have a significant impact on the commonwealth's ability to
573 meet the health care cost growth benchmark, on the competitive market or on the provider
574 organization's solvency, the institute shall conduct a cost, market impact and solvency review
575 under subsection (h).

576 (h) The institute shall establish by regulation rules for conducting cost, market impact and
577 solvency reviews where there has been a material change to a provider organization's
578 registration which the institute determines is likely to have a significant impact on the
579 commonwealth's ability to meet the health care cost growth benchmark, on the competitive
580 market or on the provider organization's solvency under subsection (g).

581 Within 60 days of receipt of a notice of a material change filed under subsection (g), the
582 institute shall initiate a cost, market impact and solvency review by sending the provider
583 organization a notice of a cost, market impact and solvency review which shall explain the
584 particular factors that the institute seeks to examine through the review. The institute shall notify
585 the attorney general and the division of insurance whenever it initiates a cost, market impact and
586 solvency review and shall issue a public notice soliciting comments to inform its review. The
587 attorney general may intervene in the cost, market impact and solvency review and may require
588 documents and testimony under oath from the provider organization, other providers or provider
589 organizations, private health care payers and public health care payers to inform the review. The
590 provider organization shall submit to the institute and the attorney general, within 21 days of the
591 institute's notice, a written response to the notice, including, but not limited to, any information
592 or documents sought by the institute or the attorney general which are described in the institute's
593 notice. A provider organization's written response and information provided to the attorney

594 general under this section shall be confidential and shall not be considered a public record under
595 clause Twenty-sixth of section 7 of chapter 4 or chapter 66 only until such time as the executive
596 director determines the response is complete.

597 A cost, market impact and solvency review may examine factors including, but not
598 limited to: (i) the provider organization's size and market share within its primary service areas
599 by major service category, and within its dispersed service areas; (ii) provider price, including its
600 relative prices filed with the institute; (iii) provider quality, including patient experience; (iv)
601 provider cost and cost trends in comparison to total health care expenditures statewide; (v) the
602 availability and accessibility of services similar to those provided, or proposed to be provided,
603 through the provider organization within its primary service areas and dispersed service areas;
604 (vi) the provider organization's impact on competing options for the delivery of health care
605 services within its primary service areas and dispersed service areas including, if applicable, the
606 impact on existing service providers of a provider organization's expansion, affiliation, merger
607 or acquisition, to enter a primary or dispersed service area in which it did not previously operate;
608 (vii) the methods used by the provider organization to attract patient volume and to recruit or
609 acquire health care professionals or facilities; (viii) the role of the provider organization in
610 serving at-risk, underserved and government payer patient populations, including those with
611 behavioral, substance use disorder and mental health conditions, within its primary service areas
612 and dispersed service areas; (ix) the role of the provider organization in providing low margin or
613 negative margin services within its primary service areas and dispersed service areas; (x) the
614 financial solvency of the provider organization; (xi) consumer concerns, including but not
615 limited to, complaints or other allegations that the provider organization has engaged in any

616 unfair method of competition or any unfair or deceptive act or practice; and (xii) any other
617 factors that the institute determines to be in the public interest.

618 The institute shall make factual findings and issue a final report on the cost, market
619 impact and solvency review within 60 days of initiating the cost, market impact and solvency
620 review. The institute shall forward a copy of the final report to the attorney general and the
621 division of insurance.

622 If the institute finds in its report that the provider organization proposed material change
623 will have an adverse cost, market or solvency impact, the institute shall require the provider
624 organization to submit, within 60 days, to the institute and the attorney general, a written
625 response to the institute's report. Nothing in this section shall prohibit a proposed material
626 change; provided, however, that any proposed material change that the institute determined will
627 have an adverse cost, market or solvency impact shall not be completed until at least 30 days
628 after the provider organization has submitted its written response.

629 (i) Nothing in this section shall limit the application of other laws or regulations that may
630 be applicable to a provider organization, including laws and regulations governing insurance.

631 Section 11.(a) The institute may promulgate regulations necessary to ensure the uniform
632 reporting of information from private and public health care payers, including third-party
633 administrators, that enables the institute to analyze: (i) changes over time in health insurance
634 premium levels; (ii) changes in the benefit and cost-sharing design of plans offered by these
635 payers; (iii) changes in measures of plan cost and utilization; provided that this analysis shall
636 facilitate comparison among plans and between public and private payers; and (iv) changes in
637 type of payment methods implemented by payers and the number of members covered by

638 alternative payment methodologies; provided, that this analysis shall facilitate comparison
639 among plans and plan types, including the self-insured. The institute shall adopt regulations to
640 require private and public health care payers to submit claims data, member data and provider
641 data to develop and maintain a database of health care claims data under this chapter. The
642 institute shall adopt regulations to require private and public health care payers which utilize
643 alternative payment methodologies to report on the extent to which such alternative payment
644 methodologies conform with the best practices developed by the authority under section 9 of
645 chapter 176S including, but not limited to, whether such methodologies include the risk
646 adjustment elements set out in said section 9 of said chapter 176S.

647 (b) The institute shall require the submission of data and other information from each
648 private health care payer offering small or large group health plans including, but not limited to:
649 (i) average annual individual and family plan premiums for each payer's most popular plans for a
650 representative range of group sizes, as further determined in regulations and average annual
651 individual and family plan premiums for the lowest cost plan in each group size that meets the
652 minimum standards and guidelines established by the division of insurance under section 8H of
653 chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for
654 each plan; (iii) summaries of the plan and network designs for each plan, including whether
655 behavioral, substance use disorder and mental health or other specific services are carved-out
656 from any plans; (iv) information concerning the medical and administrative expenses, including
657 medical loss ratios for each plan, using a uniform methodology and collected under section 21 of
658 chapter 176O; (v) information concerning the payer's current level of reserves and surpluses; (vi)
659 information on provider payment methods and levels; (vii) health status adjusted total medical
660 expenses by registered provider organization, provider group and local practice group and zip

661 code calculated according to the method established under section 51 of chapter 288 of the acts
662 of 2010; (viii) relative prices paid to every hospital, registered provider organization, physician
663 group, ambulatory surgical center, freestanding imaging center, mental health facility,
664 rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by
665 type of provider, with hospital inpatient and outpatient prices listed separately and product type,
666 including health maintenance organization and preferred provider organization products and
667 determined using the method established under section 52 of chapter 288 of the acts of 2010; (ix)
668 hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform
669 methodology; (x) the annual rate of growth, stated as a percentage, of the weighted average
670 relative price by provider type and product type for the payer's participating health care
671 providers, whether that rate exceeds the rate of growth of the applicable producer price index as
672 reported by the United States Bureau of Labor Statistics and identified by the commissioner of
673 insurance and whether that rate exceeds the rate of growth in projected economic growth
674 benchmark established under section 7H½ of chapter 29; and (xi) a comparison of relative prices
675 for the payer's participating health care providers by provider type which shows the weighted
676 average relative price, the extent of variation in price, stated as a percentage and identifies
677 providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than
678 10 per cent, 15 per cent and 20 per cent below the weighted average relative price.

679 (c) The institute shall require the submission of data and other information from public
680 health care payers including, but not limited to: (i) average premium rates for health insurance
681 plans offered by public payers and information concerning the actuarial assumptions that
682 underlie these premiums; (ii) average annual per-member per-month payments for enrollees in
683 MassHealth primary care clinician and fee for service programs; (iii) summaries of plan and

684 network designs for each plan or program, including whether behavioral, substance use disorder
685 and mental health or other specific services are carved-out from any plans; (iv) information
686 concerning the medical and administrative expenses, including medical loss ratios for each plan
687 or program; (v) where appropriate, information concerning the payer's current level of reserves
688 and surpluses; (vi) information on provider payment methods and levels, including information
689 concerning payment levels to each hospital for the 25 most common medical procedures
690 provided to enrollees in these programs, in a form that allows payment comparisons between
691 Medicaid programs and managed care organizations under contract to the office of Medicaid;
692 (vii) health status adjusted total medical expenses by registered provider organization, provider
693 group and local practice group and zip code calculated according to the method established under
694 section 51 of chapter 288 of the acts of 2010;; and (viii) relative prices paid to every hospital,
695 registered provider organization, physician group, ambulatory surgical center, freestanding
696 imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home
697 health provider in the payer's network, by type of provider, with hospital inpatient and outpatient
698 prices listed separately, and product type and determined using the method established under
699 section 52 of chapter 288 of the acts of 2010; (ix) hospital inpatient and outpatient costs,
700 including direct and indirect costs, according to a uniform methodology; (x) the annual rate of
701 growth, stated as a percentage, of the weighted average relative price by provider type and
702 product type for the payer's participating health care providers, whether that rate exceeds the rate
703 of growth of the applicable producer price index as reported by the United States Bureau of
704 Labor Statistics and identified by the commissioner of insurance and whether that rate exceeds
705 the rate of growth in projected economic growth benchmark established under section 7H½ of
706 chapter 29; and (xi) a comparison of relative prices for the payer's participating health care

707 providers by provider type which shows the weighted average relative price, the extent of
708 variation in price, stated as a percentage and identifies providers who are paid more than 10 per
709 cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent
710 below the weighted average relative price.

711 (d) The institute shall require the submission of data and other information from public
712 and private health care payers which utilize alternative payment contracts, including, but not
713 limited to: (i) the negotiated monthly budget for each alternative payment contract in the current
714 contract year; (ii) any applicable measures of provider performance in such alternative payment
715 contracts; and (iii) the average negotiated monthly budget weighted by member months for each
716 geographic region of the commonwealth as further defined in regulations promulgated by the
717 institute.

718 For purposes of this subsection, payers shall report the negotiated monthly budget
719 assuming a neutral health status score of 1.0 using an industry accepted health status adjustment
720 tool and shall separately report the budget allowances for: all medical and behavioral, substance
721 use disorder and mental health care at both in and out-of-network providers; pharmacy coverage
722 allowance; administrative expenses such as data analytics, health information technology,
723 clinical program development and other program management fees; the purchase of reinsurance
724 or stop-loss; and quality bonus monies, unit cost adjustments or other special allowances as may
725 be required in regulations promulgated by the institute. If out-of-network care, behavioral,
726 substance use disorder and mental health, stop-loss insurance or any other clinical services are
727 carved out of any global budget, bundled payments or other alternative payment methodologies
728 such that there is no allowance included in the budget for those services, payers shall report

729 actual claims costs of these items on a per member per month basis for the year immediately
730 prior to the current contract year.

731 (e) Except as specifically provided otherwise by the institute or under this chapter, insurer
732 data collected by the institute under this section shall not be a public record under clause
733 Twenty-sixth of section 7 of chapter 4 or under chapter 66.

734 Section 12. The institute shall ensure the timely reporting of information required under
735 sections 9, 10 and 11. The institute shall notify payers, providers and provider organizations of
736 any applicable reporting deadlines. The institute shall notify, in writing, a private health care
737 payer, provider or provider organization, which has failed to meet a reporting deadline and that
738 failure to respond within 2 weeks of the receipt of the notice may result in penalties. The institute
739 may assess a penalty against a payer, provider or provider organization that fails, without just
740 cause, to provide the requested information within 2 weeks following receipt of the written
741 notice required under this paragraph, of up to \$1,000 per week for each week of delay after the 2
742 week period following the payer's, provider's or provider organization's receipt of the written
743 notice; provided, however, that the maximum annual penalty against a private payer under this
744 section shall be \$50,000. Amounts collected under this section shall be deposited in the
745 Healthcare Payment Reform Fund.

746 Section 13. (a) The institute shall be the sole repository for health care data collected
747 under sections 9, 10 and 11. The institute shall collect, store and maintain such data in a payer
748 and provider claims database. The institute shall acquire, retain and oversee all information
749 technology, infrastructure, hardware, components, servers and employees necessary to carry out
750 this section. All other agencies, authorities, councils, boards and commissions of the

751 commonwealth seeking health care data that is collected under this section shall, whenever
752 feasible, utilize such data prior to requesting data directly from health care providers and payers.
753 In order to ensure patient data confidentiality, the institute shall not contract or transfer the
754 operation of the database or its functions to a third-party entity, nonprofit organization or
755 governmental entity; provided, however, that the institute may enter into interagency services
756 agreements for transfer and use of the data.

757 The institute shall, to the extent feasible, make data in the payer and provider claims
758 database available to payers and providers in real-time; provided, that all such data-sharing
759 complies with applicable state and federal privacy laws. The institute may charge a fee for real-
760 time access to such data.

761 (b) The institute shall permit providers, provider organizations, public and private health
762 care payers, government agencies and researchers to access de-identified, aggregated data
763 collected by the institute for the purposes of lowering total medical expenses, coordinating care,
764 benchmarking, quality analysis and other research, administrative or planning purposes,
765 provided, that such data shall not include information that would allow the identification of the
766 health information of an individual patient or the disclosure of rates of payment in individual
767 provider agreements. The institute shall charge user fees sufficient to defray the institute's cost
768 of providing such access to non-governmental entities.

769 Section 14. The institute shall, before adopting reporting regulations under this chapter,
770 consult with other agencies of the commonwealth and the federal government, affected
771 providers, provider organizations and affected payers, as applicable, to ensure that the reporting
772 requirements imposed under the regulations are not duplicative or excessive. If reporting

773 requirements imposed by the institute result in additional costs for the reporting providers, these
774 costs may be included in any rates promulgated by the executive office of health and human
775 services or a governmental unit designated by the executive office for these providers. The
776 institute may specify categories of information which may be furnished under an assurance of
777 confidentiality to the provider; provided that such assurance shall only be furnished if the
778 information is not to be used for setting rates.

779 Section 15. (a) The institute shall publish an annual report based on the information
780 submitted under sections 9, 10 and 11 concerning health care provider, provider organization and
781 private and public health care payer costs and cost trends. The institute shall compare such costs
782 and cost trends with the health care cost growth benchmark established by the health care quality
783 and finance authority under section 5 of chapter 176S and shall detail: (i) baseline information
784 about cost, price, quality, utilization and market power in the commonwealth's health care
785 system; (ii) factors that contribute to cost growth within the commonwealth's health care system
786 and to the relationship between provider costs and payer premium rates; (iii) the impact of health
787 care reform efforts on health care costs including, but not limited to, the development of limited
788 and tiered networks, increased price transparency, increased utilization of electronic medical
789 records and other health technology and increased prevalence of alternative payment contracts
790 and provider organizations with integrated care networks; (iv) the impact of any assessments
791 including, but not limited to, the health system benefit surcharge collected under section 68 of
792 chapter 118E, on health insurance premiums; (v) trends in utilization of unnecessary or
793 duplicative services, with particular emphasis on imaging and other high-cost services (vi) the
794 prevalence and trends in adoption of alternative payment methodologies and impact of
795 alternative payment methodologies on overall health care spending, insurance premiums and

796 provider rates; and (vii) the development and status of provider organizations in the
797 commonwealth including, but not limited to, the formation of provider organizations with
798 integrated care networks, acquisitions, mergers, consolidations and any evidence of excess
799 consolidation or anti-competitive behavior by provider organizations.

800 As part of its annual report, the institute shall report on price variation between health
801 care providers, by payer and provider type. The institute's report shall include: (i) baseline
802 information about price variation between health care providers by payer including, but not
803 limited to, identifying providers or provider organizations that are paid more than 10 per cent
804 above or more than 10 per cent below the weighted average relative price and identifying payers
805 which have entered into alternative payment contracts that vary by more than 10 per cent; (ii) the
806 annual change in price variation, by payer, among the payer's participating providers; (iii)
807 factors that contribute to price variation in the commonwealth's health care system; (iv) the
808 impact of price variations on disproportionate share hospitals and other safety net providers; and
809 (v) the impact of health reform efforts on price variation including, but not limited to, the impact
810 of increased price transparency, increased prevalence of alternative payment contracts and
811 provider organizations with integrated care networks.

812 The institute shall publish and provide the report to the health care quality and finance
813 authority, at least 30 days before any hearing required under section 4 of chapter 176S. The
814 institute may contract with an outside organization with expertise in issues related to the topics
815 of the hearings to produce this report.

816 (b) The attorney general may review and analyze any information submitted to the
817 institute under said sections 9, 10 and 11. The attorney general may require that any provider,

818 provider organization or payer produce documents, answer interrogatories and provide testimony
819 under oath related to health care costs and cost trends, factors that contribute to cost growth
820 within the commonwealth's health care system and the relationship between provider costs and
821 payer premium rates. The attorney general shall keep confidential all nonpublic information and
822 documents obtained under this section and shall not disclose such information or documents to
823 any person without the consent of the provider or payer that produced the information or
824 documents except in a public hearing under section 6 of chapter 176S, a rate hearing before the
825 division of insurance or in a case brought by the attorney general, if the attorney general believes
826 that such disclosure will promote the health care cost containment goals of the commonwealth
827 and that such disclosure should be made in the public interest after taking into account any
828 privacy, trade secret or anti-competitive considerations. Such confidential information and
829 documents shall not be public records and shall be exempt from disclosure under clause Twenty-
830 sixth of section 7 of chapter 4 or section 10 of chapter 66.

831 (c) The institute shall participate in the annual hearing required by section 6 of chapter
832 176S and advise and assist the health care quality and finance authority in conducting such
833 hearing including, but not limited to, identifying witnesses and examining and cross-examining
834 providers, provider organizations and payers regarding any issues material to the subject of such
835 hearings.

836 (d) The institute shall provide technical assistance to the health care quality and finance
837 authority, in compiling the annual report required by section 6 of chapter 176S including, but not
838 limited to, providing access to any data collected by the institute under sections 9, 10 and 11 and
839 providing analysis regarding spending trends and factors underlying such spending trends.

840 Section 16. The institute shall perform ongoing analysis of data it receives under sections
841 9, 10 and 11 to identify any payers, providers or provider organizations whose increase in health
842 status adjusted total medical expense is considered excessive and who threaten the ability of the
843 state to meet the health care cost growth benchmark established by the health care quality and
844 finance authority under section 5 of chapter 176S. The institute shall confidentially provide a list
845 of such payers, providers and provider organizations to the health care quality and finance
846 authority such that the authority may pursue further action under section 7 of chapter 176S.

847 Section 17. (a) No provider organization may negotiate network contracts with any
848 carrier or third-party administrator except for provider organizations which are registered under
849 this chapter and regulations promulgated under this chapter; provided, however, that nothing in
850 this chapter shall require a provider organization which receives, or which represents providers
851 who collectively receive, less than \$500,000 in annual net patient service revenue from carriers
852 or third-party administrators and which has fewer than 5 affiliated physicians to be registered if
853 such provider organization does not accept risk

854 (b) Nothing in this chapter shall require a carrier to negotiate a network contract with a
855 registered provider organization or with a registered provider organization for all providers that
856 are part of, or represented by, a registered provider organization.

857 Section 18. The institute shall review and comment upon all capital expenditure projects
858 requiring a determination of need under section 25C of chapter 111, including, but not limited to,
859 the availability and accessibility of services similar to those provided, or proposed to be
860 provided, through the provider organization within its primary service areas and dispersed
861 service areas; the provider organization's impact on competing options for the delivery of health

862 care services within its primary service areas and dispersed service areas; less costly or more
863 effective alternative financing methods for such projects; the immediate and long-term financial
864 feasibility of such projects; the probable impact of the project on costs of and charges for
865 services; and the availability of funds for capital and operating needs. The institute shall transmit
866 to the department of public health its written recommendations on each project which shall
867 become part of the written record compiled by said department during its review of such project.
868 The institute shall appear and comment on any application for a determination of need where a
869 public hearing is required under said section 25C of said chapter 111. To carry out this
870 paragraph, the institute shall appoint a senior professional employee to act as a liaison with said
871 department.

872 Section 19. The institute shall establish a continuing program of investigation and study
873 of the uninsured and underinsured in the commonwealth, including the health insurance needs of
874 the residents of the geographically isolated or rural areas of the commonwealth. Said continuing
875 investigation and study shall examine the overall impact of programs developed by the institute
876 and the division of medical assistance on the uninsured, the underinsured and the role of
877 employers in assisting their employees in affording health insurance.

878 Section 20. The institute shall, in consultation with the health care quality and finance
879 authority, maintain a consumer health information website. The website shall contain
880 information comparing the quality, price and cost of health care services and may also contain
881 general health care information as the institute considers appropriate. The website shall be
882 designed to assist consumers in making informed decisions regarding their medical care and
883 informed choices among health care providers. Information shall be presented in a format that is

884 understandable to the average consumer. The institute shall take appropriate action to publicize
885 the availability of its website.

886 The institute shall annually develop and adopt a reporting plan specifying the quality,
887 price and cost measures to be included on the consumer health information website and the
888 security measures used to maintain confidentiality and preserve the integrity of the data. In
889 developing the reporting plan, the institute, to the extent possible, shall collaborate with other
890 organizations or state or federal agencies that develop, collect and publicly report health care
891 quality, price and cost measures and the institute shall give priority to those measures that are
892 already available in the public domain. As part of the reporting plan, the institute shall determine
893 for each service the comparative information to be included on the consumer health information
894 website, including whether to: (i) list services separately or as part of a group of related services;
895 or (ii) combine the price and cost information for each facility and its affiliated clinicians and
896 physician practices or to list facility and professional price and costs separately.

897 The institute shall, after due consideration and public hearing, adopt the reporting plan
898 and adopt or reject any revisions. If the institute rejects the reporting plan or any revisions, the
899 institute shall state its reasons for the rejection. The reporting plan and any revisions adopted by
900 the institute shall be promulgated by the institute. The institute shall submit the reporting plan
901 and any periodic revisions to the chairs of the house and senate committees on ways and means
902 and the chairs of the joint committee on health care financing and the clerks of the house and
903 senate.

904 The website shall provide updated information on a regular basis, at least annually, and
905 additional comparative quality, price and cost information shall be published as determined by

906 the institute. To the extent possible, the website shall include: (i) comparative quality
907 information by facility, clinician or physician group practice for each service or category of
908 service for which comparative price and cost information is provided; (ii) general information
909 related to each service or category of service for which comparative information is provided; (iii)
910 comparative quality information by facility, clinician or physician practice that is not service-
911 specific, including information related to patient safety, satisfaction and confidence; and (iv) data
912 concerning healthcare-acquired infections and serious reportable events reported under section
913 51H of chapter 111. In establishing and maintaining the website, the institute shall rely on
914 industry standards for usability, including standards which are relevant for low-income
915 consumers and consumers with limited literacy. The website shall comply with the Americans
916 with Disabilities Act, and shall indicate which provider services are physically and
917 programmatically accessible, including access to physical examination equipment for people
918 with disabilities.

919 Section 21. The institute shall coordinate with the public health council and the boards of
920 registration for health care providers to develop a uniform and interoperable electronic system of
921 public reporting for providers as a condition of licensure. The uniform provider licensure
922 reporting system shall include information designed for health resource planning and for analysis
923 of market share by provider organization by primary service areas and dispersed service areas,
924 including, but not limited to, reporting for each licensed provider its principal business locations;
925 the categories of services provided; the provider organization with which the provider is
926 affiliated for contracting purposes, or by which the provider is employed, if any; whether and to
927 what extent the provider is practicing on license; and such other factors as the institute deems

928 appropriate. The institute may centralize the uniform provider licensure reporting system or
929 create a central portal for public access to the uniform provider licensure information.

930 Section 22. Any provider of health care services that receives reimbursement or payment
931 for treatment of injured workers under chapter 152 and any provider of health care services other
932 than an acute or non-acute hospital that receives reimbursement or payment from any
933 governmental unit for general health supplies, care and rehabilitative services and
934 accommodations, shall, as a condition of such reimbursement or payment: (1) permit the
935 executive director, or the executive director's designated representative and the attorney general
936 or a designee, to examine such books and accounts as may reasonably be required for the
937 institute to perform its duties; (2) file with the executive director from time to time or on request,
938 such data, statistics, schedules or other information as the institute may reasonably require,
939 including outcome data and such information regarding the costs, if any, of such provider for
940 research in the basic biomedical or health delivery areas or for the training of health care
941 personnel which are included in the provider's charges to the public for health care services,
942 supplies and accommodations; and (3) accept reimbursement or payment at the rates established
943 by the secretary of health and human services or a governmental unit designated by the executive
944 office, subject to a right of appeal under section 13E of chapter 118E, as discharging in full any
945 and all obligations of an eligible person and the governmental unit to pay, reimburse or
946 compensate the provider of health care services in any way for general health supplies, care and
947 rehabilitative services or accommodations provided.

948 Any provider of health care services that knowingly fails to file with the institute data,
949 statistics, schedules or other information required under this section or by any regulation

950 promulgated by the institute or knowingly falsifies the same shall be punished by a fine of not
951 less than \$100 nor more than \$500.

952 If, upon application by the institute or its designated representative, the superior court
953 upon summary hearing determines that a provider of health care services has, without justifiable
954 cause, refused to permit any examination or to furnish information, as required in this section, it
955 shall issue an order directing all governmental units to withhold payment for general health
956 supplies, care and rehabilitative services and accommodations to such provider of services until
957 further order of the court.

958 In addition, the appropriate licensing authority may suspend or revoke, after an
959 adjudicatory proceeding under chapter 30A, the license of any provider of health care services
960 that knowingly fails to file with the institute data, statistics, schedules or other information
961 required by this section or by any regulation of the institute or that knowingly falsifies the same.

962 SECTION 15. Section 18 of chapter 15A of the General Laws, as appearing in the 2010
963 Official Edition, is hereby amended by striking out, in lines 14 and 36, the words “division of
964 health care finance and policy” and inserting in place thereof, in each instance, the following
965 words:- commonwealth health insurance connector.

966 SECTION 16. Section 8H of chapter 26 of the General Laws, as so appearing, is hereby
967 amended by striking out, in lines 60, 64, 71 and 73 and 74 the word “division” and inserting in
968 place thereof, in each instance, the following word:- institute.

969 SECTION 17. Said section 8H of said chapter 26, as so appearing, is hereby further
970 amended by striking out, in lines 56, 77 and 78, each time they appear, the words

971 “uncompensated care pool under section 18 of chapter 118G” and inserting in place thereof, in
972 each instance, the following words:- health safety net under chapter 118E .

973 SECTION 18. Chapter 29 of the General Laws is hereby amended by inserting after
974 section 7H the following section:-

975 Section 7H ½. (a) As used in this section the following words shall, unless the context
976 clearly requires otherwise, have the following meanings:-

977 “Actual economic growth benchmark,” the actual annual percentage change in the per
978 capita state’s gross state product, as established by the secretary of administration and finance in
979 subsection (c).

980 “Projected economic growth benchmark,” the long-term average projected percentage
981 change in the per capita state’s gross state product, excluding business cycles.

982 (b) On or before January 15, the secretary of administration and finance shall meet with
983 the house and senate committees on ways and means and shall jointly develop a projected
984 economic growth benchmark for the ensuing calendar year which shall be agreed to by the
985 secretary and said committees. In developing a projected economic growth benchmark the
986 secretary and said committees, or subcommittees of said committees, may hold joint hearings on
987 the economy of the commonwealth; provided, however, that in the first year of the term of office
988 of a governor who has not served in the preceding year, said parties shall agree to the projected
989 economic growth benchmark not later than January 31 of said year. The secretary and the
990 committees may agree to incorporate this hearing into any consensus tax revenue forecast
991 hearing held under section 5B. The projected economic growth benchmark shall be included
992 with the consensus tax revenue forecast joint resolution under said section 5B and placed before

993 the members of the general court for their consideration. Such joint resolution, if passed by both
994 branches of the general court, shall establish the projected economic growth benchmark to be
995 used by the health care quality and finance authority to establish the health care cost growth
996 benchmark under section 5 of chapter 176S.

997 (c) Not later than September 15 of each year, the secretary shall report the actual
998 economic growth benchmark for the previous calendar year, based on the best information
999 available at the time. The information shall be provided to the health care quality and finance
1000 authority established under chapter 176S.

1001 SECTION 19. Section 2000 of chapter 29 of the General Laws, as so appearing, is
1002 hereby amended by striking out, in line 6, the words “18B of chapter 118G” and inserting in
1003 place thereof the following words:- 18 of chapter 176Q.

1004 SECTION 20. Said section 2000 of said chapter 29, as so appearing, is hereby further
1005 amended by striking out, in line 16, the words “established by section 18 of chapter 118G”.

1006 SECTION 21. Section 2PPP of said chapter 29, as so appearing, is hereby amended by
1007 striking out, in lines 16 and 17, the words “section 35 of chapter 118G” and inserting in place
1008 thereof the following words:- section 65 of chapter 118E.

1009 SECTION 22. Section 2RRR of said chapter 29 of the General Laws, as so appearing, is
1010 hereby amended by striking out, in lines 5 to 10, inclusive, the words “(a) any receipts from the
1011 assessment collected under section 27 of chapter 118G, including transfers by the department of
1012 developmental services of amounts sufficient to pay the assessment for public facilities, (b) any
1013 federal financial participation received by the commonwealth as a result of expenditures funded
1014 by such assessments, and (c) any interest thereon” and inserting in place thereof the following

1015 words:- (a) any federal financial participation received by the commonwealth as a result of
1016 expenditures funded by such assessments, and (b) any interest thereon.

1017 SECTION 23. Chapter 29 of the General Laws is hereby amended by inserting after
1018 section 2EEEE the following section:-

1019 Section 2FFFF. There shall be established upon the books of the commonwealth a
1020 separate fund to be known as the Health Care Workforce Transformation Fund to be expended,
1021 without further appropriation, by the secretary of labor and workforce development. The fund
1022 shall consist of any funds that may be appropriated or transferred for deposit into the trust fund,
1023 public and private sources such as gifts, grants and donations to further health care workforce
1024 development and interest earned on such revenues, and other sources.

1025 The secretary of labor and workforce development as trustee, shall administer the fund.
1026 The secretary, in consultation with the Health Care Workforce Advisory Board established in
1027 subsection (c), shall make expenditures from this account consistent with the subsections (e) and
1028 (f); provided, that not more than 10 per cent of the amounts held in the fund in any 1 year shall
1029 be used by the secretary for the combined cost of program administration, technical assistance to
1030 grantees and program evaluation.

1031 (b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall
1032 not revert to the General Fund and shall be available for expenditure in the following fiscal year.

1033 (c) There shall be Health Care Workforce Advisory Board constituted to make
1034 recommendations to the secretary concerning the administration and allocation of the fund,
1035 establish evaluation criteria and perform any other functions specifically granted to it by law.

1036 The board shall consist of the following members: the secretary of labor and workforce
1037 development, who shall serve as chair; the executive director of the institute of health care
1038 finance and policy or a designee; the commissioner of public health or a designee, and no more
1039 than 13 members who shall be appointed by the secretary of labor and workforce development
1040 and who shall reflect a broad distribution of diverse perspectives on the health care system and
1041 health care workforce needs, including health care professionals, labor organizations, educational
1042 institutions, consumer representatives, providers and payers.

1043 The secretary shall, under the advice and guidance of the Health Care Workforce
1044 Advisory Board, annually report on its strategy for administration and allocation of the fund,
1045 including relevant evaluation criteria, and short-term and long-term programmatic and policy
1046 recommendations to improve workforce performance.

1047 (d) All expenditures from the Health Care Workforce Transformation Fund shall have 1
1048 or more of the following purposes:-

1049 (i) support the development and implementation of employer and work programs
1050 to enhance worker skills, income, productivity and retention rates;

1051 (ii) address critical workforce shortages;

1052 (iii) address workforce needs identified in the health resource plan developed
1053 under section 25A of chapter 111;

1054 (iv) improve employment in the health care industry for the unemployed or low-
1055 income individuals and low-wage workers;

1056 (v) provide training or educational services for currently employed or unemployed
1057 health care workers who are seeking new positions or responsibilities within the health care
1058 industry;

1059 (vi) provide training or educational services for existing health care workers in
1060 emerging fields of care delivery models;

1061 (vii) provide loan repayment and incentive programs for health care workers;

1062 (viii) provide career ladder programs for health care workers; or

1063 (ix) any other purpose the secretary, in consultation with the Health Care
1064 Workforce Advisory Board, determines.

1065 (e) The secretary shall establish a competitive grant process funded by the Health Care
1066 Workforce Transformation Fund to eligible applicants to provide education and training to health
1067 care workers. Eligible applicants shall include: employers and employer associations; local
1068 workforce investment boards; labor organizations; joint labor-management partnerships;
1069 community-based organizations; institutions of higher education; vocational education
1070 institutions; one-stop career centers; local workforce development entities; and any partnership
1071 or collaboration between eligible applicants. Expenditures from the fund for such purposes shall
1072 complement and not replace existing local, state, private, or federal funding for training and
1073 educational programs.

1074 (f) A grant proposal submitted under subsection (e) shall include, but not be limited to:

1075 (i) a plan that defines specific goals for health care workforce training and
1076 educational improvements over a multi-year period in specific areas;

- 1077 (ii) the evidence-based programs the applicant shall use to meet the goals;
- 1078 (iii) a budget necessary to implement the plan, including a detailed description of
1079 any funding or in-kind contributions the applicant or applicants will be providing in support of
1080 the proposal;
- 1081 (iv) any other private funding or private sector participation the applicant
1082 anticipates in support of the proposal; and
- 1083 (v) the anticipated number of individuals who would receive a benefit due to the
1084 implementation of the plan.

1085 Priority may be given to proposals that target areas of critical labor needs for the health
1086 care industry or that are projected to be critical labor needs of the health care industry in the near
1087 future. Priority may also be given to proposals that target geographic areas with specific health
1088 care workforce needs or that target geographic areas with unemployment levels higher than the
1089 state average. If no proposals were offered in areas of particular need, the secretary may
1090 provide technical assistance and planning grant funding directly to eligible applicants in order to
1091 develop grant proposals.

1092 The secretary shall, in consultation with the Health Care Workforce Advisory Board,
1093 develop guidelines for an annual review of the progress being made by each grantee. Each
1094 grantee shall participate in any evaluation or accountability process implemented by or
1095 authorized by the secretary.

1096 (g) The secretary shall annually expend not less than 20 per cent of available funds in the
1097 Health Care Workforce Transformation Fund to expand training and loan forgiveness programs

1098 for primary care providers in the commonwealth. The training and loan forgiveness programs
1099 for primary care providers shall include, but not be limited to:

1100 (i) The secretary shall establish a competitive primary care residency grant process
1101 funded by the Health Care Workforce Transformation Fund to eligible applicants for the purpose
1102 of financing the training of primary care providers at teaching community health centers. Eligible
1103 applicants shall include teaching community health centers accredited through affiliations with a
1104 commonwealth funded medical school or licensed as part of a teaching hospital with a residency
1105 program in primary care or family medicine and teaching health centers that are the
1106 independently accredited sponsoring organization for the residency program and whose residents
1107 are employed by the health center.

1108 To receive funding, an applicant shall (a) include a review of recent graduates of the
1109 teaching community health center's residency program, including information regarding what
1110 type of practice said graduates are involved in 2 years following graduation from the residency
1111 program; and (b) achieve a threshold of at least 50 per cent for the percentage of graduates
1112 practicing primary care within 2 years after graduation. Graduates practicing (a) more than 50
1113 per cent inpatient care or (b) more than 50 per cent specialty care, as listed in the American
1114 Medical Association Masterfile, shall not qualify as graduates practicing primary care.

1115 Awardees of the primary care residency grant program shall maintain their teaching
1116 accreditation as either an independent teaching community health center or as a teaching
1117 community health center accredited through affiliation with a commonwealth funded medical
1118 school or licensed as part of a teaching hospital.

1119 (ii) A primary care workforce development and loan forgiveness grant program at
1120 community health centers, for the purpose of enhancing recruitment and retention of primary
1121 care physicians and other clinicians at community health centers throughout the commonwealth.
1122 The grant program shall be administered by the department of public health; provided, that the
1123 department may contract with an organization to administer the grant program. Funds for the
1124 grant program shall be matched by other public or private funds.

1125 (iii) The health care provider workforce loan repayment program, established in section
1126 25N of chapter 111, as administered by the department of public health.

1127 (h) The comptroller shall annually transfer not less than 10 per cent of available funds in
1128 the Health Care Workforce Transformation Fund to the Massachusetts Nursing and Allied Health
1129 Workforce Development Trust Fund established in section 33 of chapter 305 of the acts of 2008
1130 to develop and support strategies that increase the number of public higher education faculty
1131 members and students who participate in programs that support careers in fields related to
1132 nursing and allied health.

1133 (i) The secretary shall, annually on or before January 31, report on expenditures from the
1134 Health Care Workforce Transformation Fund. The report shall include, but shall not be limited
1135 to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the
1136 administrative costs of the secretary of labor and workforce development; (iii) an itemized list of
1137 the funds expended through the competitive grant process and a description of the grantee
1138 activities; and (iv) the results of the evaluation of the effectiveness of the activities funded
1139 through grants. The report shall be provided to the chairs of the house and senate committees on
1140 ways and means, the joint committee on public health, the joint committee on health care

1141 financing and the joint committee on labor and workforce development and shall be posted on
1142 the department of public health's website.

1143 (j) The secretary of labor and workforce development may promulgate appropriate
1144 regulations to carry out this section.

1145 SECTION 24. Section 1 of chapter 29D of the General Laws, as so appearing, is hereby
1146 amended by striking out, in line 13, the words "25 and 26 of chapter 118G" and inserting in
1147 place thereof the following words:- 63 of chapter 118E.

1148 SECTION 25. Section 3 of said chapter 29D, as so appearing, is hereby amended by
1149 striking out, in line 18, the words "25 and 26 of chapter 118G" and inserting in place thereof the
1150 following words:- 63 of chapter 118E.

1151 SECTION 26. Said section 3 of said chapter 29D, as so appearing, is hereby amended by
1152 striking out, in line 22, the words "25 and 26 of said chapter 118G" and inserting in place thereof
1153 the following words:- 63 of said chapter 118E.

1154 SECTION 27. Section 1 of chapter 32 of the General Laws, as so appearing, is hereby
1155 amended by inserting after the word "connector", in line 216, the following words:- the health
1156 care quality and finance authority.

1157 SECTION 28. Section 2 of chapter 32A of the General Laws, as so appearing, is hereby
1158 amended by inserting after the word "authority", in line 12, the following words:- the health care
1159 quality and finance authority.

1160 SECTION 29. Chapter 40J of the General Laws is hereby amended by striking out
1161 sections 6D and 6E, as so appearing, and inserting in place thereof the following 2 sections:-

1162 Section 6D. (a) There shall be established an institute for health care innovation,
1163 technology and competitiveness, to be known as the Massachusetts e-Health Institute. The
1164 executive director of the corporation shall appoint a qualified individual to serve as the director
1165 of the institute, who shall be an employee of the corporation, report to the executive director and
1166 manage the affairs of the institute. The institute shall advance the dissemination of health
1167 information technology across the commonwealth, including the deployment of interoperable
1168 electronic health records systems in all health care provider settings that are networked through a
1169 statewide health information exchange.

1170 (b) There shall be established a health information technology council within the
1171 corporation. The council shall advise the institute on the dissemination of health information
1172 technology across the commonwealth, including the deployment of interoperable electronic
1173 health records systems in all health care provider settings that are networked through a statewide
1174 health information exchange.

1175 The council shall consist of 18 members: 1 of whom shall be the secretary of
1176 administration and finance, who shall serve as chair; 1 of whom shall be the secretary of health
1177 and human services; 1 of whom shall be the executive director of the institute of health care
1178 finance and policy or a designee; 1 of whom shall be the secretary of housing and economic
1179 development or a designee; 14 of whom shall be appointed by the governor, at least 1 of whom
1180 shall be an expert in health information technology, 1 of whom shall be an expert in state and
1181 federal health privacy laws, 1 of whom shall be an expert in health policy, 1 of whom shall be an
1182 expert in health information technology relative to privacy and security, 1 of whom shall be from
1183 an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be
1184 from a community health center, 1 of whom shall be from a long term care facility, 1 of whom

1185 shall be from a physician group practice, 1 of whom shall be a non-physician health care
1186 provider, 1 of whom shall be a registered nurse, 1 of whom shall be a member from a behavioral
1187 health, substance abuse disorder or mental health services organization and 2 of whom shall
1188 represent the health insurance carriers. The council may consult with such parties, public or
1189 private, as it deems desirable in exercising its duties under this section, including persons with
1190 expertise and experience in the development and dissemination of interoperable electronic health
1191 records systems and the implementation of interoperable electronic health record systems by
1192 small physician groups or ambulatory care providers as well as persons representing
1193 organizations within the commonwealth interested in and affected by the development of
1194 networks and interoperable electronic health records systems, including, but not limited to,
1195 persons representing local public health agencies, licensed hospitals and other licensed facilities
1196 and providers, private purchasers, community-based behavioral providers, substance use disorder
1197 and mental health care providers, the medical and nursing professions, physicians, health
1198 insurers and health plans, the state quality improvement organization, academic and research
1199 institutions, consumer advisory organizations with expertise in health information technology
1200 and other stakeholders as identified by the secretary of health and human services. Appointive
1201 members of the council shall serve for terms of 2 years or until a successor is appointed.

1202 Members shall be eligible to be reappointed and shall serve without compensation.

1203 The members of the council shall be deemed to be directors for purposes of the fourth
1204 paragraph of section 3. Chapter 268A shall apply to all council members except that the council
1205 may purchase from, sell to, borrow from, contract with or otherwise deal with any organization
1206 in which any council member is in anyway interested or involved; provided, however, that such
1207 interest or involvement shall be disclosed in advance to the council and recorded in the minutes

1208 of the proceedings of the council; and provided further, that no member shall be deemed to have
1209 violated section 4 of said chapter 268A because of such member's receipt of the member's usual
1210 and regular compensation from the member's employer during the time in which the member
1211 participates in the activities of the council.

1212 (c) The institute, in consultation with the council, shall advance the dissemination of
1213 health information technology and support the state's efforts in meeting the health care cost
1214 growth benchmark established under section 5 of chapter 176S by: (i) facilitating the
1215 implementation and use of interoperable electronic health records systems by health care
1216 providers in order to improve health care delivery and coordination, reduce unwarranted
1217 treatment variation, eliminate wasteful paper-based processes, help facilitate chronic disease
1218 management initiatives and establish transparency; (ii) facilitating the creation and maintenance
1219 of a statewide interoperable electronic health records network that allows individual health care
1220 providers in all health care settings to exchange patient health information with other
1221 providers;(iii) identifying and promoting an accelerated dissemination in the commonwealth of
1222 emerging health care technologies that have been developed and employed and that are expected
1223 to improve health care quality and lower health care costs, but that have not been widely
1224 implemented in the commonwealth, including, but not limited to, evidence-based clinical
1225 decision support and image exchange tools for advanced diagnostic imaging services; (iv)
1226 facilitating health care providers in achieving and maintaining compliance with the standards for
1227 meaningful use, beyond stage 1, established by regulation by the United States Department of
1228 Health and Human Services under the Health Information Technology for Economic and Clinical
1229 Health Act and referred to in this section as "meaningful use"; and (v) promoting to patients,
1230 providers and the general public, a broad understanding of the benefits of interoperable

1231 electronic health records systems for care delivery, care coordination, improved quality and
1232 ultimately greater cost efficiency in the health care delivery system.

1233 (d) The institute director shall prepare and annually update a statewide electronic health
1234 records plan. Each plan shall contain a budget for the application of funds from the e-Health
1235 Institute Fund for use in implementing each such plan. The institute director shall submit such
1236 plans and updates, and associated budgets, to the council for its review and comment. Each such
1237 plan and the associated budget shall be subject to approval of the board following consideration
1238 on it by the council.

1239 Components of each such plan, as updated, shall be community-based implementation
1240 plans that assess a municipality's or region's readiness to implement and use electronic health
1241 record systems and an interoperable electronic health records network within the referral market
1242 for a defined patient population. Each such implementation plan shall address the development,
1243 implementation and dissemination of interoperable electronic health records systems among
1244 health care providers in the community or region, particularly providers, such as community
1245 health centers and community-based behavioral, substance use disorder and mental health care
1246 providers that serve underserved populations, including, but not limited to, racial, ethnic and
1247 linguistic minorities, uninsured persons and areas with a high proportion of public payer care.

1248 Each plan as updated shall: (i) allow seamless, secure electronic exchange of health
1249 information among health care providers, health plans and other authorized users; (ii) provide
1250 consumers with secure, electronic access to their own health information; (iii) meet all applicable
1251 federal and state privacy and security requirements, including requirements imposed by 45
1252 C.F.R. §§ 160, 162 and 164; (iv) meet standards for interoperability adopted by the institute after

1253 consultation with the council; (v) give patients the option of allowing only designated health care
1254 providers to disseminate their individually identifiable information; (vi) provide public health
1255 reporting capability as required under state law; (vii) support any activities funded by the
1256 Healthcare Payment Reform Fund; and (viii) allow reporting of health information other than
1257 identifiable patient health information for purposes of such activities as the secretary of health
1258 and human services may consider necessary.

1259 (e) The corporation may contract with implementing organizations to: (i) facilitate a
1260 public-private partnership that includes representation from hospitals, physicians and other
1261 health care professionals, health insurers, employers and other health care purchasers, health data
1262 and service organizations and consumer organizations; (ii) provide resources and support to
1263 recipients of grants awarded under subsection (f) to implement each program within the
1264 designated community pursuant to the implementation plan; (iii) certify and disburse funds to
1265 subcontractors, when necessary; (iv) provide technical assistance to facilitate successful practice
1266 redesign, adoption of electronic health records and utilization of care management strategies; (v)
1267 ensure that electronic health records systems are fully interoperable and secure and that sensitive
1268 patient information is kept confidential by exclusively utilizing electronic health records
1269 products that are certified by the Office of the National Coordinator under the federal Health
1270 Information Technology for Economic and Clinical Health Act; and (vi) certify, with approval of
1271 the corporation, a group of subcontractors who shall provide the necessary hardware and
1272 software for system implementation. Prior to the institute's issuing requests for proposals for
1273 contracts to be entered into under this section, the institute's director shall consult with the
1274 council with respect to the content of all such proposals.

1275 (f) Funding for the institute and council’s activities shall be through the e-Health Institute
1276 Fund, established in section 6E. The institute, in consultation with the council, shall develop
1277 mechanisms for funding health information technology, including a grant program to assist
1278 health care providers with costs associated with health information technologies, including
1279 electronic health records systems, and coordinated with other electronic health records projects
1280 seeking federal reimbursement. Providers eligible for receipt of amounts from the Fund shall be
1281 limited to (i) any individual or institutional provider of health care services that is not in a
1282 category of individual or institutional provider eligible to receive Medicare or Medicaid
1283 incentive payments under the federal Health Information Technology for Economic and Clinical
1284 Health Act, such payments being referred to in this subsection as “incentive payments,” and that
1285 lack access, as reasonably determined by the director of the institute, to resources needed to
1286 implement interoperable electronic health records systems that satisfy standards established by
1287 the institute; and (ii) physicians, hospitals and community health centers that are eligible for
1288 incentive payments but lack access, as reasonably determined by the director of the institute, to
1289 resources needed to support their meeting meaningful use standards as determined in accordance
1290 with the federal Health Information Technology for Economic and Clinical Health Act.
1291 Individual or institutional providers under clause (i) may include, but shall not be limited to,
1292 mental health facilities and community-based behavioral, substance use disorder and mental
1293 health care providers, chronic care and rehabilitation hospitals, skilled nursing facilities, visiting
1294 nursing associations, home health providers, registered nurses, licensed practical nurses,
1295 physicians, physician assistants, chiropractors, dentists, occupational therapists, physical
1296 therapists, optometrists, pharmacists, podiatrists, psychologists and social workers. In making the

1297 determinations regarding available resources as described in clauses (i) and (ii), the director of
1298 the institute shall consider:

1299 (1) the demonstrated need for investment, taking into account all resources
1300 available to the particular provider including the relationship or affiliation of the particular
1301 provider to a health care delivery system and the capacity of such system to provide financial
1302 support for the provider's meeting the standards established by the institute or meaningful use
1303 standards;

1304 (2) the anticipated return on investment, as measured by improved health care
1305 coordination, reduction in health care costs, reduction in unwarranted treatment variation and
1306 elimination of wasteful paper-based processes;

1307 (3) the amount of financial or in-kind support the particular provider will commit
1308 to supplementing or supporting any investment by the corporation;

1309 (4) whether there is a reasonable likelihood that the provider's use of such
1310 amounts will achieve the long term benefits expected from implementing an interoperable
1311 electronic health records system;

1312 (5) whether the investment will support innovative health care delivery and
1313 payment models as identified by the health care quality and finance authority;

1314 (6) whether the investment will support efforts to integrate mental health,
1315 behavioral and substance use disorder services with overall medical care;

1316 (7) the extent to which the investment will support efforts to meet the health care
1317 cost growth benchmark established by the health care quality and finance authority; and

1318 (8) whether the provider serves a high proportion of public payer clients; and (9)
1319 any other factors that the director determines are appropriate.

1320 The institute shall consult with the office of Medicaid to maximize all opportunities to
1321 qualify any expenditures for federal financial participation. Applications for funding shall be in
1322 the form and manner determined by the institute director, and shall include the information and
1323 assurances required by the institute director. The institute director may consider, as a condition
1324 for awarding grants, the grantee's financial participation and any other factors it deems relevant.

1325 All grants shall be recommended by the institute director and subsequently approved by
1326 the executive director. The institute director shall work with implementation organizations to
1327 oversee the grant-making process as it relates to an implementing organization's responsibilities
1328 under its contract with the corporation. Each recipient of monies from this program shall: (i)
1329 capture and report certain quality improvement data, as determined by the institute in
1330 consultation with the department of public health and the institute of health care finance and
1331 policy; (ii) fully implement an electronic health record system, including all clinical features,
1332 with such interoperability as may be feasible at the time, not later than the second year of the
1333 grant; and (iii) make use of the system's full range of features. In the event that any recipient of
1334 grant monies from this program does not achieve installation of a fully functioning electronic
1335 health record system or does not achieve the appropriate level of interoperability within the 2
1336 year grant period, such recipient shall be required to repay to the corporation all or some portion,
1337 as determined by the corporation, of the grant funds previously provided to such recipient under
1338 this section.

1339 (g) The institute shall establish a pilot partnership with community colleges or vocational
1340 technology schools in the commonwealth to support health information technology curriculum
1341 development and workforce development. Any funding for such a program from the e-Health
1342 Institute Fund shall be recommended by the institute director and approved by the executive
1343 director.

1344 (h) The council shall receive staff assistance from the corporation.

1345 (i) The institute shall file an annual report, not later than January 30, with the joint
1346 committee on health care financing, the joint committee on economic development and emerging
1347 technologies and the house and senate committees on ways and means concerning the activities
1348 of the council in general and, in particular, describing the progress to date in implementing a
1349 statewide interoperable electronic health records system and recommending such further
1350 legislative action as it deems appropriate.

1351 Section 6E. (a) There shall be established and set up on the books of the corporation a
1352 separate fund to be known as the e-Health Institute Fund, referred to in this section as the fund.
1353 There shall be credited to the fund revenue from appropriations or other monies authorized by
1354 the general court and specifically designated to be credited to the fund, including but not limited
1355 to, amounts to be credited to the fund under subsection (a) of section 70 of chapter 118E, any
1356 investment income earned on the fund's assets and all other sources. The corporation shall hold
1357 the fund in an account or accounts separate from other funds, including other funds established
1358 under this chapter. Amounts credited to the fund shall be available for reasonable expenditure by
1359 the corporation, without further appropriation, for any and all activities consistent with this
1360 section and supportive of the purposes specified in section 6D, including but not limited to, in the

1361 form of grants, contracts, loans and such other vehicles as the corporation may determine are
1362 appropriate. Amounts credited to the fund shall be expended or applied only with the approval
1363 of the executive director of the corporation upon consultation with the director of the institute as
1364 provided in this section. No amounts credited to the fund shall be applied to the
1365 commonwealth's match for federal funds for which a state match is required unless the federal
1366 funds to be matched are allocated to the corporation for use to further the purposes set out in this
1367 section, as reasonably determined by the executive director of the corporation; provided that
1368 there are no other sources of funds available to meet federal matching requirements in order to
1369 secure such federal funds, as reasonably determined by the executive director of the corporation.
1370 Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert
1371 to the General Fund and shall be available for expenditure in the following fiscal year.

1372 SECTION 30. Section 8B of chapter 62C of the General Laws, as so appearing, is hereby
1373 amended by striking out, in line 28, the word "division", the second time it appears, and inserting
1374 in place thereof the following word:- institute.

1375 SECTION 31. Clause (22) of subsection (b) of section 21 of said chapter 62C, as so
1376 appearing, is hereby amended by striking out, in lines 141 and 142, the words "division of health
1377 care finance and policy" and inserting in place thereof the following words:- executive office of
1378 health and human services.

1379 SECTION 32. Said clause (22) of said subsection (b) of said section 21 of said chapter
1380 62C, as so appearing, is hereby further amended by striking out, in line 143, the word "118G"
1381 and inserting in place thereof the following word:- 118E.

1382 SECTION 33. Clause (23) of said subsection (b) of said section 21 of said chapter 62C,
1383 as so appearing, is hereby amended by striking out, in line 145, the words “division of health
1384 care finance and policy” and inserting in place thereof the following words:- executive office of
1385 health and human services.

1386 SECTION 34. Said clause (23) of said subsection (b) of said section 21 of said chapter
1387 62C, as so appearing, is hereby further amended by striking out, in lines 48 and 49, the words
1388 “section 39 of chapter 118G” and inserting in place thereof the following words:- section 69 of
1389 chapter 118E.

1390 SECTION 35. Section 1 of chapter 62D of the General Laws, as amended by section 13
1391 of chapter 142 of the acts of 2011, is hereby amended by striking out, in lines 8 to 10, the words
1392 “the division of health care finance and policy in the exercise of its duty to administer the
1393 uncompensated care pool pursuant to chapter 118G” and inserting in place thereof the following
1394 words:- the executive office of health and human services in the exercise of its duty to administer
1395 the Health Safety Net Trust Fund under chapter 118E.

1396 SECTION 36. Said section 1 of said chapter 62D, as so amended, is hereby further
1397 amended by striking out the words “division of health care finance and policy on behalf of the
1398 uncompensated care pool by a person or a guarantor of a person who received free care services
1399 paid for in whole or in part by the uncompensated care pool or on whose behalf the
1400 uncompensated care pool paid for emergency bad debt, pursuant to subsection (m) of section 18
1401 of chapter 118G” and inserting in place thereof the following words:- executive office of health
1402 and human services on behalf of the Health Safety Net Trust Fund by a person or a guarantor of

1403 a person who received free care services paid for in whole or in part by the Health Safety Net
1404 Trust Fund or on whose behalf said fund paid for emergency bad debt.

1405 SECTION 37. Said section 1 of said chapter 62D, as so amended, is hereby further
1406 amended by striking out, in line 55, the words “section 39 of chapter 118G” and inserting in
1407 place thereof the following words:- section 69 of chapter 118E.

1408 SECTION 38. Section 8 of said chapter 62D, as appearing in the 2010 Official Edition, is
1409 hereby amended by striking out the second paragraph.

1410 SECTION 39. Section 10 of said chapter 62D, as so appearing, is hereby amended by
1411 striking out, in lines 8 and 9, the words “the division of medical assistance, the corporation, the
1412 office of the state comptroller, and the division of health care finance and policy” and inserting
1413 in place thereof the following words:- the office of medicaid, the corporation, the office of the
1414 state comptroller and the executive office of health and human services.

1415 SECTION 40. Section 13 of said chapter 62D, as amended by section 14 of chapter 142
1416 of the acts of 2011, is hereby further amended by striking out the words “section 39 of chapter
1417 118G” and inserting in place thereof the following words:- section 69 of chapter 118E.

1418 SECTION 41. Section 3 of chapter 62E of the General Laws, as appearing in the 2010
1419 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words “division of
1420 health care finance and policy” and inserting in place thereof the following words:- executive
1421 office of health and human services.

1422 SECTION 42. Section 12 of said chapter 62E, as so appearing, is hereby amended by
1423 striking out, in lines 19 and 20, the words “division of health care finance and policy” and
1424 inserting in place thereof the following words:- executive office of health and human services.

1425 SECTION 43. Said section 12 of said chapter 62E, as so appearing, is hereby amended by
1426 striking out, in lines 21 to 22, the words “sections 34 to 39, inclusive, of chapter 118G and
1427 sections 6B, 6C and 18B of chapter 118G” and inserting in place thereof the following words:-
1428 sections 64 to 69, inclusive, of chapter 118E and sections 17 and 18 of chapter 176Q.

1429 SECTION 44. Section 17A of chapter 66 of the General Laws, as so appearing, is hereby
1430 amended by striking out, in line 11, the word “118G” and inserting in place thereof the following
1431 word:- 118E.

1432 SECTION 45. Section 3 of chapter 71B of the General Laws, as so appearing, is hereby
1433 amended by striking out, in line 177, the words “2A of chapter 118G” and inserting in place
1434 thereof the following words:- 13C of chapter 118E.

1435 SECTION 46. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby
1436 amended by striking out the definition of “Board of health” and inserting in place thereof the
1437 following 2 definitions:-

1438 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health
1439 care provider for health care services provided to an insured.

1440 “Board of health”, shall include the board or officer having like powers and duties in
1441 towns where there is no board of health.

1442 SECTION 47. Said section 1 of said chapter 111, as so appearing, is hereby further
1443 amended by striking out the definition of “Medical peer review committee” or “committee”, and
1444 inserting in place thereof the following definition:-

1445 “Medical peer review committee” or “committee”, a committee of health care providers,
1446 which functions to: (i) evaluate or improve the quality of health care rendered by providers of
1447 health care services; (ii) determine whether health care services were performed in compliance
1448 with the applicable standards of care; (iii) determine whether the costs of health care services
1449 were performed in compliance with the applicable standards of care; (iv) determine whether the
1450 cost of the health care services rendered were considered reasonable by the providers of health
1451 services in the area; (v) determine whether a health care provider’s actions call into question
1452 such health care provider’s fitness to provide health care services; or (vi) evaluate and assist
1453 health care providers impaired or allegedly impaired by reason of alcohol, drugs, physical
1454 disability, mental instability or otherwise; provided further, that “medical peer review
1455 committee” shall also include: (i) a committee of a pharmacy society or association that is
1456 authorized to evaluate the quality of pharmacy services or the competence of pharmacists and
1457 suggest improvements in pharmacy systems to enhance patient care; or (ii) a pharmacy peer
1458 review committee established by a person or entity that owns a licensed pharmacy or employs
1459 pharmacists that is authorized to evaluate the quality of pharmacy services or the competence of
1460 pharmacists and suggest improvements in pharmacy systems to enhance patient care.

1461 SECTION 48. Said chapter 111 is hereby further amended by inserting after section 2F
1462 the following 2 sections:-

1463 Section 2G. (a) There shall be established and set upon the books of the commonwealth a
1464 separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without
1465 further appropriation, by the department of public health. The fund shall consist of health system
1466 benefit surcharge revenues collected by the commonwealth under section 68 of chapter 118E,
1467 public and private sources such as gifts, grants and donations to further community-based
1468 prevention activities, interest earned on such revenues and any funds provided from other
1469 sources.

1470 The commissioner of public health, as trustee, shall administer the fund. The
1471 commissioner, in consultation with the Prevention and Wellness Advisory Board established
1472 under section 2H, shall make expenditures from the fund consistent with subsections (d) and (e);
1473 provided, that not more than 15 per cent of the amounts held in the fund in any 1 year shall be
1474 used by the department for the combined cost of program administration, technical assistance to
1475 grantees or program evaluation.

1476 (b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall
1477 not revert to the General Fund and shall be available for expenditure in the following fiscal year.

1478 (c) All expenditures from the Prevention and Wellness Trust Fund shall support the
1479 state's efforts to meet the health care cost growth benchmark established in section 5 of chapter
1480 176S and any activities funded by the Healthcare Payment Reform Fund and 1 or more of the
1481 following purposes: (i) reduce rates of the most prevalent and preventable health conditions,
1482 including substance abuse; (ii) increase healthy behaviors, including the management of chronic
1483 diseases; (iii) increase the adoption of workplace-based wellness or health management

1484 programs that result in positive returns on investment for employees and employers; (iv) address
1485 health disparities; or (v) develop a stronger evidence-base of effective prevention programming.

1486 (d) The commissioner shall annually award not less than 75 per cent of the Prevention
1487 and Wellness Trust Fund through a competitive grant process to municipalities, community-
1488 based organizations, health care providers, regional-planning agencies and health plans that
1489 apply for the implementation, evaluation and dissemination of evidence-based community
1490 preventive health activities. To be eligible to receive a grant under this subsection, a recipient
1491 shall be: (i) a municipality or group of municipalities working in collaboration; (ii) a community-
1492 based organization working in collaboration with 1 or more municipalities; (iii) a health care
1493 provider or a health plan working in collaboration with 1 or more municipalities and a
1494 community-based organization; or (iv) a regional planning agency. Expenditures from the fund
1495 for such purposes shall supplement and not replace existing local, state, private or federal public
1496 health-related funding.

1497 (e) A grant proposal submitted under subsection (d) shall include, but not be limited to:
1498 (i) a plan that defines specific goals for the reduction in preventable health conditions and health
1499 care costs over a multi-year period; (ii) the evidence-based programs the applicant shall use to
1500 meet the goals; (iii) a budget necessary to implement the plan, including a detailed description of
1501 any funding or in-kind contributions the applicant or applicants will be providing in support of
1502 the proposal; (iv) any other private funding or private sector participation the applicant
1503 anticipates in support of the proposal; (v) a commitment to include women, racial and ethnic
1504 minorities and low income individuals; and (vi) the anticipated number of individuals that would
1505 be affected by implementation of the plan.

1506 Priority may be given to proposals in a geographic region of the state with a higher than
1507 average prevalence of preventable health conditions, as determined by the commissioner of
1508 public health, in consultation with the Prevention and Wellness Advisory Board. If no proposals
1509 were offered in areas of the state with particular need, the department shall ask for a specific
1510 request for proposal for that specific region. If the commissioner determines that no suitable
1511 proposals have been received, such that the specific needs remain unmet, the department may
1512 work directly with municipalities or community-based organizations to develop grant proposals.

1513 The department of public health shall, in consultation with the Prevention and Wellness
1514 Advisory Board, develop guidelines for an annual review of the progress being made by each
1515 grantee. Each grantee shall participate in any evaluation or accountability process implemented
1516 or authorized by the department.

1517 (f) The commissioner of public health may annually expend not more than 10 per cent of
1518 the Prevention and Wellness Trust Fund to support the increased adoption of workplace-based
1519 wellness or health management programming. The department of public health shall expend
1520 such funds for activities including, but not limited to: (i) developing and distributing
1521 informational tool-kits for employers, including a model wellness guide developed by the
1522 department; (ii) providing technical assistance to employers implementing wellness programs;
1523 (iii) hosting informational forums for employers; (iv) promoting awareness of wellness tax
1524 credits provided through the state and federal government, including the wellness subsidy
1525 provided by the commonwealth health connector authority; (v) public information campaigns
1526 that quantify the importance of healthy lifestyles, disease prevention, care management and
1527 health promotion programs; and (vi) providing stipends or grants to employers for the
1528 implementation and administration of workplace wellness programs in an amount up to 50 per

1529 cent of the costs associated with implementing the plan, subject to a cap as established by the
1530 commissioner based on available funds.

1531 The department of public health shall develop guidelines to annually review progress
1532 toward increasing the adoption of workplace-based wellness or health management
1533 programming.

1534 (g) The department of public health shall, annually on or before January 31, report on
1535 expenditures from the Prevention and Wellness Trust Fund. The report shall include, but not be
1536 limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable
1537 to the administrative costs of the department of public health; (iii) an itemized list of the funds
1538 expended through the competitive grant process and a description of the grantee activities; (iv)
1539 the results of the evaluation of the effectiveness of the activities funded through grants; and (v)
1540 an itemized list of expenditures used to support workplace-based wellness or health management
1541 programs. The report shall be provided to the chairs of the house and senate committees on ways
1542 and means and the joint committee on public health and shall be posted on the department of
1543 public health's website.

1544 (h) The department of public health shall, under the advice and guidance of the
1545 Prevention and Wellness Advisory Board, annually report on its strategy for administration and
1546 allocation of the fund, including relevant evaluation criteria. The report shall set forth the
1547 rationale for such strategy, including, but not limited to: (i) a list of the most prevalent
1548 preventable health conditions in the commonwealth, including health disparities experienced by
1549 populations based on race, ethnicity, gender, disability status, sexual orientation or socio-
1550 economic status; (ii) a list of the most costly preventable health conditions in the commonwealth;

1551 (iii) a list of evidence-based or promising community-based programs related to the conditions
1552 identified in clauses (i) and (ii); and (iv) a list of evidence-based workplace wellness programs or
1553 health management programs related to the conditions in clauses (i) and (ii). The report shall
1554 recommend specific areas of focus for allocation of funds. If appropriate, the report shall
1555 reference goals and best practices established by the National Prevention and Public Health
1556 Promotion Council and the Centers for Disease Control and Prevention, including, but not
1557 limited to the national prevention strategy, the healthy people report and the community
1558 prevention guide.

1559 (i) The department of public health may promulgate regulations to carry out this section.

1560 Section 2H. There shall be a Prevention and Wellness Advisory Board to make
1561 recommendations to the commissioner concerning the administration and allocation of the
1562 Prevention and Wellness Trust Fund established in section 2G, establish evaluation criteria and
1563 perform any other functions specifically granted to it by law.

1564 The board shall consist 17 members: 1 of whom shall be the commissioner of public
1565 health or a designee, who shall serve as chair; 1 of whom shall be the executive director of the
1566 institute of health care finance and policy established in chapter 12C or a designee; 1 of whom
1567 shall be the secretary of health and human services or a designee; and 14 of whom shall be
1568 appointed by the governor, 1 of whom shall be a person with expertise in the field of public
1569 health economics; 1 of whom shall be a person with expertise in public health research; 1 of
1570 whom shall be a person with expertise in the field of health equity; 1 of whom shall be a person
1571 from a local board of health for a city or town with a population greater than 50,000; 1 of whom
1572 shall be a person of a board of health for a city or town with a population of fewer than 50,000; 2

1573 of whom shall be representatives of health insurance carriers; 1 of whom shall be a person from a
1574 consumer health organization; 1 of whom shall be a person from a hospital association; 1 of
1575 whom shall be a person from a statewide public health organization; 1 of whom shall be a
1576 representative of the interest of businesses; 1 of whom shall administer an employee assistance
1577 program; 1 of whom shall be a public health nurse or a school nurse; and 1 of whom shall be a
1578 person from an association representing community health workers."

1579 SECTION 49. Section 4H of chapter 111 of the General Laws, as appearing in the 2010
1580 Official Edition, is hereby amended by striking out, in line 20, the words "division of health care
1581 finance and policy" and inserting in place thereof the following words:- executive office of
1582 health and human services, or a governmental unit designated by the executive office.

1583 SECTION 50. Said chapter 111 is hereby further amended by striking out section 25A, as
1584 so appearing, and inserting in place thereof the following section:-

1585 Section 25A. (a) Every 4 years the department of public health, in consultation with the
1586 institute of health care finance and policy, shall submit to the governor and the general court a 4-
1587 year health resource plan. The plan shall identify needs of the commonwealth in health care
1588 services, providers, programs and facilities; the resources available to meet those needs; and the
1589 priorities for addressing those needs on a statewide basis.

1590 (1) The plan shall include the location, distribution and nature of all health care resources
1591 in the commonwealth and shall establish and maintain on a current basis an inventory of all such
1592 resources together with all other reasonably pertinent information concerning such resources. For
1593 purposes of this section, a health care resource shall include any resource, whether personal or
1594 institutional in nature and whether owned or operated by any person, the commonwealth or

1595 political subdivision thereof, the principal purpose of which is to provide, or facilitate the
1596 provision of, services for the prevention, detection, diagnosis or treatment of those physical and
1597 mental conditions experienced by humans which usually are the result of, or result in, disease,
1598 injury, deformity, or pain.

1599 The plan shall identify certain categories of health care resources, including acute care
1600 units; non-acute care units; specialty care units, including, but not limited to, burn, coronary care,
1601 cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal
1602 dialysis and surgical, including trauma, intensive care units; skilled nursing facilities; home
1603 health, behavioral health and mental health services; treatment and prevention services for
1604 alcohol and other drug abuse; emergency care; ambulatory care services; primary care resources;
1605 pharmacy and pharmacological services; family planning services; obstetrics and gynecology
1606 services; allied health services including, but not limited to, optometric care, chiropractic
1607 services, dental care, midwifery services; federally qualified health centers and free clinics;
1608 numbers of technologies or equipment defined as innovative services or new technologies by the
1609 department under section 25C; and health screening and early intervention services.

1610 (2) The plan shall make recommendations for the appropriate supply and
1611 distribution of resources, programs, capacities, technologies and services identified in paragraph
1612 (1) based on an assessment of need for the next 4 years and options for implementing such
1613 recommendations and mechanisms. The recommendations shall reflect at least the following
1614 goals: to maintain and improve the quality of health care services; to support the state's efforts to
1615 meet the health care cost growth benchmark established under section 5 of chapter 176S; to
1616 support innovative health care delivery and alternative payment models as identified by the
1617 health care quality and finance authority; to reduce unnecessary duplication; to support universal

1618 access to community-based preventative and patient-centered primary health care; to reduce
1619 health disparities; to support efforts to integrate mental health, behavioral and substance use
1620 disorder services with overall medical care; to reflect the latest trends in utilization and support
1621 the best standards of care; and to rationally distribute health care resources across geographic
1622 regions of state based on the needs of the population on a statewide basis as well as the needs of
1623 particular geographic areas of the state.

1624 (b) To prepare the plan, the commissioner shall assemble an advisory committee of no
1625 more than 13 members who shall reflect a broad distribution of diverse perspectives on the
1626 health care system, including health care professionals, third-party payers, both public and
1627 private, consumer representatives and labor organizations. The advisory committee shall review
1628 drafts and provide recommendations to the commissioner during the development of the plan.

1629 The department, with the advisory committee, shall conduct at least 5 public hearings, in
1630 different regions of the state, with not less than 2 public hearings held in Berkshire, Franklin,
1631 Hampden or Hampshire counties, on the plan as proposed and shall give interested persons an
1632 opportunity to submit their views orally and in writing. In addition, the department may create
1633 and maintain a website to allow members of the public to submit comments electronically and
1634 review comments submitted by others.

1635 The department shall develop a mechanism for receiving ongoing public comment
1636 regarding the plan and for revising it every 4 years or as needed.

1637 (c) The department shall issue guidelines, rules, or regulations consistent with the state
1638 health plan for making determinations of need. If the commissioner determines that statutory

1639 changes are necessary to implement the plan, the commissioner shall submit legislative language
1640 to the joint committee on public health and the joint committee on health care financing.

1641 (d) The inventory compiled under subsection (a) and all related information shall be
1642 maintained in a form usable by the general public in a designated office of the department, shall
1643 constitute a public record and shall be coordinated with information collected by the department
1644 under other provisions of law, federal census information and other vital statistics from reliable
1645 sources; provided, however, that any item of information which is confidential or privileged in
1646 nature or under any other provision of law shall not be regarded as a public record under this
1647 section.

1648 (e) The department may require health care resources to provide information for the
1649 purposes of this section and may prescribe by regulation uniform reporting requirements. In
1650 prescribing such regulations the department shall strive to make any reports required under this
1651 section of mutual benefit to those providing as well as those using such information and shall
1652 avoid placing any burdens on such providers which are not reasonably necessary to accomplish
1653 this section.

1654 Agencies of the commonwealth which collect cost or other data concerning health care
1655 resources shall cooperate with the department in coordinating such data with information
1656 collected under this section.

1657 (f) The department shall publish analyses, reports and interpretations of information
1658 collected under this section to promote awareness of the distribution and nature of health care
1659 resources in the commonwealth.

1660 (g) In the performance of its duties, the department, subject to appropriation, may enter
1661 into such contracts with agencies of the federal government, the commonwealth or any political
1662 subdivision thereof and public or private bodies, as it deems necessary; provided, however, that
1663 no information received under such a contract shall be published or relied upon for any purpose
1664 by the department unless the department has determined such information to be reasonably
1665 accurate by statistical sampling or other suitable techniques for measuring the reliability of
1666 information-gathering processes.

1667 (h) The department of public health may establish an Amyotrophic Lateral Sclerosis
1668 registry, by areas and regions of the commonwealth, with specific data to be obtained from
1669 urban, low and median income communities and minority communities of the commonwealth.

1670 SECTION 51. Section 25B of said chapter 111, as so appearing, is hereby amended by
1671 striking out, in lines 23 and 24, the words “1 of chapter 118G” and inserting in place thereof the
1672 following words:- 8 of chapter 118E.

1673 SECTION 52. Said chapter 111 is hereby further amended by striking out section 25C, as
1674 so appearing, and inserting in place thereof the following section:-

1675 Section 25C. (a) Notwithstanding any general or special law to the contrary, except as
1676 provided in section 25 C½, no person or agency of the commonwealth or any political
1677 subdivision thereof shall make substantial capital expenditures for construction of a health care
1678 facility or substantially change the service of such facility unless there is a determination by the
1679 department that there is need for such construction or change. No such determination of need
1680 shall be required for any substantial capital expenditure for construction or any substantial
1681 change in service which shall be related solely to the conduct of research in the basic biomedical

1682 or applied medical research areas and shall at no time result in any increase in the clinical bed
1683 capacity or outpatient load capacity of a health care facility and shall at no time be included
1684 within or cause an increase in the gross patient service revenue of a facility for health care
1685 services, supplies and accommodations, as such revenue shall be defined under section 31 of
1686 chapter 6A. Any person undertaking any such expenditure related solely to such research which
1687 shall exceed or may reasonably be regarded as likely to exceed \$150,000 or any such change in
1688 service solely related to such research, shall give written notice of the expenditure or change in
1689 service to the department and the institute of health care finance and policy at least 60 days
1690 before undertaking such expenditure or change in service. Said notice shall state that such
1691 expenditure or change shall be related solely to the conduct of research in the basic biomedical or
1692 applied medical research areas and shall at no time be included within or result in any increase in
1693 the clinical bed capacity or outpatient load capacity of a facility and shall at no time cause an
1694 increase in the gross patient service revenue, as defined in under said section 31 of said chapter
1695 6A, of a facility for health care services, supplies and accommodations; provided, however, that
1696 if it is subsequently determined that there was a violation of this section, the applicant may be
1697 punished by a fine of not more than three times the amount of such expenditure or value of said
1698 change of service.

1699 (b) Notwithstanding subsection (a), a determination of need shall be required for any such
1700 expenditure or change if the notice required by this section is not filed in accordance with the
1701 requirements of this section or if the department finds, after receipt of said notice, that such
1702 expenditure or change will not be related solely to research in the basic biomedical or applied
1703 medical research areas, will result in an increase in the clinical bed capacity or outpatient load
1704 capacity of a facility or will be included within or cause an increase in the gross patient service

1705 revenues of a facility. A research exemption granted under this section shall not be deemed to be
1706 evidence of need in any determination of need proceeding.

1707 (c) No person or agency of the commonwealth or any political subdivision thereof shall
1708 provide an innovative service or use a new technology, in any location other than in a health care
1709 facility, unless the person or agency first is issued a determination of need for such innovative
1710 service or new technology by the department.

1711 (d) No person or agency of the commonwealth or any political subdivision thereof shall
1712 acquire for location in other than a health care facility a unit of medical, diagnostic, or
1713 therapeutic equipment, other than equipment used to provide an innovative service or which is a
1714 new technology, with a fair market value in excess of \$150,000 unless the person or agency
1715 notifies the department of the person's or agency's intent to acquire such equipment and of the
1716 use that will be made of the equipment. Such notice shall be made in writing and shall be
1717 received by the department at least 30 days before contractual arrangements are entered into to
1718 acquire the equipment with respect to which notice is given. A determination by the department
1719 of need for such equipment shall be required for any such acquisition (i) if the notice required by
1720 this subsection is not filed in accordance with the requirements of this subsection; and (ii) if the
1721 requirements for exemption under subsection (a) of section 25 C½ are not met; provided,
1722 however, that in no event shall any person who acquires a unit of magnetic resonance imaging
1723 equipment for location other than in a health care facility refer or influence any referrals of
1724 patients to said equipment, unless said person is a physician directly providing services with that
1725 equipment; provided, however, that for the purposes of this section, no public advertisement
1726 shall be deemed a referral or an influence of referrals; and provided, further, that any person who

1727 has an ownership interest in said equipment, whether direct or indirect, shall disclose said
1728 interest to patients utilizing said equipment in a conspicuous manner.

1729 (e) Each person or agency operating a unit of equipment described in this section shall
1730 submit annually to the department information and data in connection with utilization and
1731 volume rates of said equipment on a form or forms prescribed by the department.

1732 (f) Except as provided in section 25 C½, no person or agency of the commonwealth or
1733 any political subdivision thereof shall acquire an existing health care facility unless the person or
1734 agency notifies the department of the person's or agency's intent to acquire such facility and of
1735 the services to be offered in the facility and its bed capacity. Such notice shall be made in writing
1736 and shall be received by the department at least 30 days before contractual arrangements are
1737 entered into to acquire the facility with respect to which the notice is given. A determination of
1738 need shall be required for any such acquisition if the notice required by this subsection is not
1739 filed in accordance with the requirements of this subsection or if the department finds, within 30
1740 days after receipt of notice under this subsection, that the services or bed capacity of the facility
1741 will be changed in being acquired.

1742 (g) In making any such determination, the department shall encourage appropriate
1743 allocation of private and public health care resources and the development of alternative or
1744 substitute methods of delivering health care services so that adequate health care services will be
1745 made reasonably available to every person within the commonwealth at the lowest reasonable
1746 aggregate cost, shall take into account any comments from the institute of health care finance and
1747 policy pursuant to section 17 of chapter 12C, shall take into account any comments from the
1748 attorney general and shall take into account the special needs and circumstances of HMOs. The

1749 department shall also recognize the special needs and circumstances of projects that (1) are
1750 essential to the conduct of research in basic biomedical or health care delivery areas or to the
1751 training of health care personnel; (2) are deemed consistent with the recommendations of the
1752 state health resource plan filed by the department under section 25A; (3) are unlikely to result in
1753 any increase in the clinical bed capacity or outpatient load capacity of the facility; and (4) are
1754 unlikely to cause an increase in the total patient care charges of the facility to the public for
1755 health care services, supplies and accommodations, as such charges shall be defined under
1756 section 5 of chapter 409 of the acts of 1976.

1757 (h) Applications for such determination shall be filed with the department, together with
1758 such other forms and information as shall be prescribed by, or acceptable to, the department. A
1759 duplicate copy of any application together with supporting documentation for such application,
1760 shall be a public record and kept on file in the department. The department may require a public
1761 hearing on any application at its discretion or at the request of the attorney general. The attorney
1762 general may intervene in any hearing under this section. A reasonable fee, established by the
1763 department, shall be paid upon the filing of such application; provided, that in no event shall
1764 such fee exceed .1 per cent of the capital expenditures, if any, proposed by the applicant. The
1765 department may also require the applicant to provide an independent cost-analysis, conducted at
1766 the expense of the applicant, to demonstrate that the application is consistent with the
1767 commonwealth's efforts to meet the health care cost-containment goals established by the health
1768 care quality and finance authority.

1769 (i) Except in the case of an emergency situation determined by the department as
1770 requiring immediate action to prevent further damage to the public health or to a health care
1771 facility, the department shall not act upon an application for such determination unless: (1) the

1772 application has been on file with the department for at least 30 days; (2) the institute of health
1773 care finance and policy, the state and appropriate regional comprehensive health planning
1774 agencies and, in the case of long-term care facilities only, the department of elder affairs, or in
1775 the case of any facility providing inpatient services for the mentally ill or developmentally
1776 disabled, the departments of mental health or developmental services, respectively, have been
1777 provided copies of such application and supporting documents and given reasonable opportunity
1778 to comment on such application; and (3) a public hearing has been held on such application when
1779 requested by the applicant, the state or appropriate regional comprehensive health planning
1780 agency or any 10 taxpayers of the commonwealth. If, in any filing period, an individual
1781 application is filed which would implicitly decide any other application filed during such period,
1782 the department shall not act only upon an individual.

1783 (j) The department shall so approve or disapprove in whole or in part each such
1784 application for a determination of need within 4 months after filing with the department;
1785 provided that the department may, on 1 occasion only, delay such action for up to 2 months after
1786 the applicant has provided information which the department reasonably has requested during
1787 such 8 month period. Applications remanded to the department by the health facilities appeals
1788 board under section 25E shall be acted upon by the department within the same time limits
1789 provided in this section for the department to approve or disapprove applications for a
1790 determination of need. If an application has not been acted upon by the department within such
1791 time limits, the applicant may, within a reasonable period of time, bring an action in the nature of
1792 mandamus in the superior court to require the department to act upon the application.

1793 (k) Determinations of need shall be based on the written record compiled by the
1794 department during its review of the application and on such criteria consistent with sections 25B

1795 to 25G, inclusive, as were in effect on the date of filing of the application. In compiling such
1796 record the department shall confine its requests for information from the applicant to matters
1797 which shall be within the normal capacity of the applicant to provide. In each case the action by
1798 the department on the application shall be in writing and shall set forth the reasons for such
1799 action; and every such action and the reasons for such action shall constitute a public record and
1800 be filed in the department.

1801 (l) The department shall stipulate the period during which a determination of need shall
1802 remain in effect, which in no event shall originally be longer than 3 years but which may be
1803 extended by the department for cause shown. Any such determination shall continue to be
1804 effective only upon the applicant: (i) making reasonable progress toward completing the
1805 construction or substantial change in services for which need was determined to exist; (ii)
1806 complying with all other laws relating to the construction, licensure and operation of health care
1807 facilities; and (iii) complying with such further terms and conditions as the department
1808 reasonably shall require.

1809 (m) The department shall notify the secretary of elder affairs forthwith of the pendency of
1810 any proceeding, of any public hearing and of any action to be taken under this section on any
1811 application submitted by or on behalf of any long-term care facility. In instances involving
1812 applications submitted on behalf of any facility providing inpatient services for the mentally ill
1813 or developmentally disabled, the department shall notify the appropriate commissioner.

1814 (n) No long-term care facility located in an under-bedded urban area shall be replaced or
1815 the license for said facility transferred outside an under-bedded urban area. For the purposes of
1816 this subsection, an under-bedded urban area shall mean a city or town in which: (i) the per capita

1817 income is below the state average; (ii) the percentage of the population below 100 per cent of the
1818 federal poverty level is above the state average; or (iii) the percentage of the population below
1819 200 per cent of the federal poverty level is above the state average.

1820 SECTION 53. Said chapter 111 is hereby further amended by striking out section 25L, as
1821 amended by section 114 of chapter 3 of the acts of 2011, and inserting in place thereof the
1822 following section:-

1823 Section 25L. (a) There shall be in the department a health care provider workforce center
1824 to improve access to health and behavioral, substance use disorder and mental health care
1825 services. The center, in consultation with the healthcare provider workforce advisory council
1826 established by section 25M and the secretary of labor and workforce development, shall: (i)
1827 coordinate the department's health care workforce activities with other state agencies and public
1828 and private entities involved in health care workforce training, recruitment and retention,
1829 including with the activities of the Health Care Workforce Transformation Fund; (ii) monitor
1830 trends in access to primary care providers, nurse practitioners and physician assistants practicing
1831 as primary care providers, behavioral, substance use disorder and mental health providers and
1832 other physician and nursing providers, through activities including: (1) review of existing data
1833 and collection of new data as needed to assess the capacity of the health care and behavioral,
1834 substance use disorder and mental health care workforce to serve patients, including patient
1835 access and regional disparities in access to physicians, physician assistants, nurses and
1836 behavioral, substance use disorder and mental health professionals and to examine physician,
1837 physician assistant, nursing and behavioral, substance use disorder and mental health
1838 professionals' satisfaction; (2) review existing laws, regulations, policies, contracting or
1839 reimbursement practices and other factors that influence recruitment and retention of physicians,

1840 physician assistants, nurses and behavioral, substance use disorder and mental health
1841 professionals; (3) making projections on the ability of the workforce to meet the needs of
1842 patients over time; (4) identifying strategies currently being employed to address workforce
1843 needs, shortages, recruitment and retention; (5) studying the capacity of public and private
1844 medical, nursing and behavioral, substance use disorder and mental health professional schools
1845 in the commonwealth to expand the supply of primary care physicians, nurse practitioners and
1846 physician assistants practicing as primary care providers, and licensed behavioral, substance use
1847 disorder and mental health professionals; (iii) establish criteria to identify underserved areas in
1848 the commonwealth for administering the loan repayment program established under section 25N
1849 and for determining statewide target areas for health care provider placement based on the level
1850 of access; and (iv) address health care workforce shortages by: (1) coordinating state and federal
1851 loan repayment and incentive programs for health care providers; (2) providing assistance and
1852 support to communities, physician groups, community health centers, community based
1853 behavioral, substance use disorder and mental health organizations and community hospitals in
1854 developing cost-effective and comprehensive recruitment initiatives; (3) maximizing all sources
1855 of public and private funds for recruitment initiatives; (4) designing pilot programs and make
1856 regulatory and legislative proposals to address workforce needs, shortages, recruitment and
1857 retention; and (5) making short-term and long-term programmatic and policy recommendations
1858 to improve workforce performance, address identified workforce shortages and recruit and retain
1859 physicians, physician assistants, nurses and behavioral, substance use disorder and mental health
1860 professionals.

1861 (b) The center shall communicate and coordinate with the institute for health care finance
1862 and policy, the health care quality and finance authority, the secretary of labor and workforce
1863 development, and the health disparities council, established by section 16O of said chapter 6A.

1864 (c) The center shall annually submit a report, not later than March 1, to the governor; and
1865 the general court, by filing the report with the clerks of the house of representatives and the
1866 senate, the joint committee on labor and workforce development, the joint committee on health
1867 care financing and the joint committee on public health. The report shall include: (i) data on
1868 patient access and regional disparities in access to physicians, by specialty and sub-specialty,
1869 behavioral, substance use disorder and mental health professionals and nurses; (ii) data on factors
1870 influencing recruitment and retention of physicians, nurses and behavioral, substance use
1871 disorder and mental health professionals; (iii) short and long-term projections of physicians,
1872 nurses and behavioral, substance use disorder and mental health professionals supply and
1873 demand; (iv) strategies being employed by the council or other entities to address workforce
1874 needs, shortages, recruitment and retention; (v) recommendations for designing, implementing
1875 and improving programs or policies to address workforce needs, shortages, recruitment and
1876 retention; and (vi) proposals for statutory or regulatory changes to address workforce needs,
1877 shortages, recruitment and retention.

1878 SECTION 54. Said chapter 111 is hereby further amended by striking out sections 25M
1879 and 25N, as appearing in the 2010 Official Edition, and inserting in place thereof the following 2
1880 sections:-

1881 Section 25M. (a) There shall be a healthcare provider workforce advisory council within,
1882 but not subject to the control of, the health care provider workforce center established by section

1883 25L. The council shall advise the center on the capacity of the healthcare workforce to provide
1884 timely, effective, culturally competent, quality physician, nursing and behavioral, substance use
1885 disorder and mental health services.

1886 (b) The council shall consist of 19 members, 1 of whom shall be the commissioner of
1887 public health, who shall serve as chair; 3 of whom who shall be appointed by the governor: 1 of
1888 whom shall be a physician with a primary care specialty designation; 1 of whom shall be an
1889 advanced practice nurse, authorized under section 80B of said chapter 112; 1 of whom shall be a
1890 behavioral, substance use disorder and mental health professional; and 1 person from each of the
1891 following organizations who shall be appointed by the secretary of health and human services
1892 from a list of nominees submitted by the organization: the Association for Behavioral
1893 Healthcare; the Massachusetts Psychiatric Society; the Massachusetts Psychological Association;
1894 the National Association of Social Workers Massachusetts Chapter; the Massachusetts Extended
1895 Care Federation; the Organization of Nurse Leaders; the Massachusetts Academy of Family
1896 Physicians; the Massachusetts League of Community Health Centers, Inc.; the Massachusetts
1897 Medical Society; the Massachusetts Nurses Association; the Massachusetts Association of
1898 Physician Assistants; the Massachusetts Association of Registered Nurses; the Massachusetts
1899 Hospital Association, Inc.; the Massachusetts Chiropractic Society, Inc.; and Health Care For
1900 All, Inc. Members of the council shall be appointed for a term of 3 years or until a successor is
1901 appointed. Members shall be eligible to be reappointed and shall serve without compensation,
1902 but may be reimbursed for actual and necessary expenses reasonably incurred in the performance
1903 of their duties. Vacancies of unexpired terms shall be filled within 60 days by the appropriate
1904 appointing authority.

1905 The council shall meet at least bimonthly, at other times as determined by its rules and
1906 when requested by any 8 members.

1907 (c) The council shall advise the center on: (i) trends in access to primary care and
1908 physician subspecialties, nursing and behavioral, substance use disorder and mental health
1909 services; (ii) the development and administration of the loan repayment program, established
1910 under section 25N, including criteria to identify underserved areas in the commonwealth; (iii)
1911 solutions to address identified health care workforces shortages; and (iv) the center's annual
1912 report to the general court.

1913 Section 25N. (a) There shall be a health care provider workforce loan repayment
1914 program, administered by the health care provider workforce center established by section 25L.
1915 The program shall provide repayment assistance for undergraduate, graduate and medical school
1916 loans to participants who: (i) are graduates of medical or nursing schools or accredited colleges,
1917 universities or graduate schools; (ii) specialize in family health or medicine, internal medicine,
1918 pediatrics, psychiatry, obstetrics/gynecology, behavioral health, mental health or substance use
1919 disorder treatment; (iii) demonstrate competency in health information technology, including use
1920 of electronic medical records, computerized physician order entry and e-prescribing; and (iv)
1921 meet other eligibility criteria, including service requirements, established by the board. Each
1922 recipient shall be required to enter into a contract with the commonwealth which shall obligate
1923 the recipient to perform a term of service of not less than 2 years in medically underserved areas
1924 as determined by the center.

1925 (b) The center shall promulgate regulations for the administration and enforcement of this
1926 section which shall include penalties and repayment procedures if a participant fails to comply
1927 with the service contract.

1928 The center shall, in consultation with the health care workforce advisory council and the
1929 public health council, establish criteria to identify medically underserved areas within the
1930 commonwealth. These criteria shall consist of quantifiable measures, which may include the
1931 availability of primary care medical services or behavioral, substance use disorder and mental
1932 health services within reasonable traveling distance, poverty levels and disparities in health care
1933 access or health outcomes.

1934 (c) The center shall evaluate the program annually, including exit interviews of
1935 participants to determine their post-program service plans and to solicit program improvement
1936 recommendations.

1937 (d) The center shall file an annual report, not later than July 1, with the governor, the
1938 clerks of the house of representatives and the senate, the house and senate committees on ways
1939 and means, the joint committee on health care financing, the joint committee on mental health
1940 and substance abuse and the joint committee on public health. The report shall include annual
1941 data and historical trends of: (i) the number of applicants, the number accepted and the number
1942 of participants by race, gender, medical or nursing specialty, medical or nursing school,
1943 residence prior to medical or nursing school and where they plan to practice after program
1944 completion; (ii) the service placement locations and length of service commitments by
1945 participants; (iii) the number of participants who fail to fulfill the program requirements and the

1946 reason for the failures; (iv) the number of former participants who continue to serve in
1947 underserved areas; and (v) program expenditures.

1948 SECTION 55. Section 51 of said chapter 111, as so appearing, is hereby amended by
1949 striking out, in lines 25 and 26, the words “division of health care finance and policy” and
1950 inserting in place thereof the following words:- commonwealth health insurance connector.

1951 SECTION 56. Said section 51 of said chapter 111, as so appearing, is hereby further
1952 amended by striking out, in lines 25, 36 and 46, the word “division” and inserting in place
1953 thereof, in each instance, the following word:- institute.

1954 SECTION 57. Said section 51 of said chapter 111, as so appearing, is hereby further
1955 amended by striking out, in lines 27 and 28, the words “pursuant to section 18 of chapter 118G”.

1956 SECTION 58. Section 51G of said chapter 111, as so appearing, is hereby amended by
1957 inserting after the words “or services,” in line 38, the following words:- conduct a public hearing
1958 on the closure of said essential services or of the hospital. The department shall.

1959 SECTION 59. Subsection (c) of section 51H of said chapter 111, as so appearing, is
1960 hereby amended by striking out, in lines 70 and 71, the words “and to the health care quality and
1961 cost council”.

1962 SECTION 60. Said chapter 111 is hereby further amended by inserting after section 51H
1963 the following 2 sections:—

1964 Section 51I. (a) As used in this section the following words shall, unless the context
1965 clearly requires otherwise, have the following meanings:-

1966 “Adverse event”, injury to a patient resulting from a medical intervention, and not to the
1967 underlying condition of the patient.

1968 “Checklist of care”, pre-determined steps to be followed by a team of healthcare
1969 providers before, during and after a given procedure to decrease the possibility of patient harm
1970 by standardizing care.

1971 “Facility,” a hospital, institution maintaining an Intensive Care Unit, institution providing
1972 surgical services or clinic providing ambulatory surgery.

1973 (b) The department shall encourage the development and implementation of checklists of
1974 care that prevent adverse events and reduce healthcare-associated infection rates. The department
1975 shall develop model checklists of care, which may be implemented by facilities; provided
1976 however, that facilities may develop and implement checklists independently.

1977 (c) Facilities shall report data and information relative to their use or non-use of
1978 checklists to the department and the Betsy Lehman center for patient safety and medical error
1979 reduction. The department may consider facilities that use similar programs to be in compliance.
1980 The department shall publicly report on individual hospitals’ compliance rates.. Individual
1981 reports shall be kept confidential by the department and the Betsy Lehman center, but aggregated
1982 compliance rates shall be posted publicly.

1983 Section 51J. The department shall promulgate regulations regarding limited services
1984 clinics. The regulations shall promote the availability of limited services clinics as a point of
1985 access for health care services within the full scope of practice of a nurse practitioner or other
1986 clinician providing services.

1987 SECTION 60A. Section 52 of said chapter 111, as so appearing, is hereby amended by
1988 inserting, after the definition of “Institution for unwed mothers” the following 2 definitions:-

1989 “Limited services”, diagnosis, treatment, management and monitoring of acute and
1990 chronic disease, wellness and preventative services of a nature that may be provided within the
1991 scope of practice of a nurse practitioner or other clinician providing services using available
1992 facilities and equipment, including shared toilet facilities for point-of-care testing.

1993 “Limited services clinic”, a clinic that provides limited services.

1994 SECTION 61. Said chapter 111 is hereby further amended by inserting, after section
1995 53G, the following section:-

1996 Section 53H. No hospital shall enter into a contract or agreement, which creates or
1997 establishes a partnership, employment or any other professional relationship with a licensed
1998 physician that would prohibit or limit the ability of said physician to provide testimony in an
1999 administrative or judicial hearing, including cases of medical malpractice.

2000 SECTION 62. Section 62M of said chapter 111, as so appearing, is hereby amended by
2001 striking out, in line 13, the words “division of health care finance and policy” and inserting in
2002 place thereof the following words:- executive office of health and human services or a
2003 governmental unit designated by the executive office.

2004 SECTION 63. Section 67C of said chapter 111, as so appearing, is hereby amended by
2005 striking out, in line 8, the words “division of health care finance and policy” and inserting in
2006 place thereof the following words:- executive office of health and human services.

2007 SECTION 64. Section 69H of said chapter 111, as so appearing, is hereby amended by
2008 striking out, in lines 2 and 3, the words “division of health care finance and policy” and inserting
2009 in place thereof the following words:- executive office of health and human services or a
2010 governmental unit designated by the executive office.

2011 SECTION 64A. Said chapter 111, as so appearing, is hereby amended by inserting after
2012 section 70G the following section:-

2013 Section 70H. Notwithstanding chapter 93A, sections 70E, 72E and 73 and 940 CMR
2014 section 4.09, a facility or institution licensed by the department of public health under section 71
2015 may move a resident to different living quarters or to a different room within the facility or
2016 institution if, as documented in the resident’s clinical record and as certified by a physician, the
2017 resident’s clinical needs have changed such that the resident either (1) requires specialized
2018 accommodations, care, services, technologies, staffing not customarily provided in connection
2019 with the resident’s living quarters or room, or (2) ceases to require the specialized
2020 accommodations, care, services, technologies or staffing customarily provided in connection
2021 with the resident’s living quarters or room; provided, however, that nothing in this section shall
2022 obviate a resident's notice and hearing rights when movement to different living quarters
2023 involves a resident moving from a Medicare-certified unit to a non-Medicare-certified unit or
2024 involves a resident moving from a non-Medicare-certified unit to a Medicare-certified unit;
2025 provided, however, that the resident shall have the right to appeal to the facility’s or institution’s
2026 medical director a decision to move the resident to a different living quarter or to a different
2027 room within the facility or institution.

2028 SECTION 65. Section 72P of said chapter 111, as so appearing, is hereby amended by
2029 striking out, in line 20, the word “division” and inserting in place thereof the following word:-
2030 institute.

2031 SECTION 66. Section 72Q of said chapter 111, as so appearing, is hereby amended by
2032 striking out, in line 2, the word “division” and inserting in place thereof the following word:-
2033 institute.

2034 SECTION 67. Section 72Y of said chapter 111, as so appearing, is hereby amended by
2035 striking out, in lines 43 and 47, the words “7 of chapter 118G” and inserting in place thereof, in
2036 each instance, the following words:- 13D of chapter 118E.

2037 SECTION 68. Section 78 of said chapter 111, as so appearing, is hereby amended by
2038 striking out, in lines 19 and 20, the words “division of health care finance and policy” and
2039 inserting in place thereof the following words:- executive office of health and human services or
2040 a governmental unit designated by the executive office.

2041 SECTION 69. Section 78A of said chapter 111, as so appearing, is hereby amended by
2042 striking out, in line 14, the words “division of health care finance and policy” and inserting in
2043 place thereof the following words:- executive office of health and human services or a
2044 governmental unit designated by the executive office.

2045 SECTION 70. Section 79 of said chapter 111, as so appearing, is hereby amended by
2046 striking out, in line 9, the words “division of health care finance and policy” and inserting in
2047 place thereof the following words:- executive office of health and human services or a
2048 governmental unit designated by the executive office.

2049 SECTION 71. Section 80 of said chapter 111, as so appearing, is hereby amended by
2050 striking out, in lines 5 and 6, the words “division of health care finance and policy” and inserting
2051 in place thereof the following words:- executive office of health and human services or a
2052 governmental unit designated by the executive office.

2053 SECTION 72. Said section 80 of said chapter 111, as so appearing, is hereby further
2054 amended by striking out, in line 8, the word “division” and inserting in place thereof the
2055 following words:- executive office.

2056 SECTION 73. Section 82 of said chapter 111, as so appearing, is hereby amended by
2057 striking out, in lines 22 and 23, the words “division of health care finance and policy” and
2058 inserting in place thereof the following words:- executive office of health and human services or
2059 a governmental unit designated by the executive office.

2060 SECTION 74. Said section 82 of said chapter 111, as so appearing, is hereby further
2061 amended by striking out, in line 24, the word “division” and inserting in place thereof the
2062 following words:- executive office.

2063 SECTION 75. Section 88 of said chapter 111, as so appearing, is hereby amended by
2064 striking out, in line 16, the words “division of health care finance and policy” and inserting in
2065 place thereof the following words:- executive office of health and human services or a
2066 governmental unit designated by the executive office.

2067 SECTION 76. Section 116A of said chapter 111, as so appearing, is hereby amended by
2068 striking out, in line 2, the words “division of health care finance and policy” and inserting in
2069 place thereof the following words:- executive office of health and human services or a
2070 governmental unit designated by the executive office.

2071 SECTION 77. Section 204 of said chapter 111, as so appearing, is hereby amended by
2072 adding the following subsection:-

2073 (f) This section shall apply to any committee formed by an individual or group to perform
2074 the duties or functions of medical peer review, notwithstanding the fact that the formation of the
2075 committee is not required by law or regulation or that the individual or group is not solely
2076 affiliated with a public hospital, licensed hospital, nursing home or health maintenance
2077 organization.

2078 SECTION 78. Section 217 of said chapter 111, as so appearing, is hereby amended by
2079 striking out, in lines 16 and 17, the words “the health plan report card developed pursuant to
2080 section 24 of chapter 118G”.

2081 SECTION 79. Subsection (a) of section 217 of said chapter 111, as so appearing, is
2082 hereby amended by striking out, in line 33, the word “and”.

2083 SECTION 80. Said subsection (a) of said section 217 of said chapter 111, as so
2084 appearing, is hereby further amended by adding the following 3 paragraphs:-

2085 (8) have the authority to promulgate regulations establishing safeguards to protect
2086 consumers from inappropriate denials of services or treatment in connection with utilization of
2087 any alternative payment methodologies, as defined in section 1 of chapter 12C;

2088 (9) have the authority to promulgate regulations, in consultation with the division of
2089 insurance, establishing safeguards against, and penalties for, inappropriate selection of low cost
2090 patients and avoidance of high cost patients by any provider or provider organization accepting
2091 alternative payment methodologies, as such terms are defined in section 1 of chapter 12C; and

2092 (10) regulate the appeals processes established in section 23 of chapter 176O and
2093 establish, by regulation, minimum standards for fair, fast and objective review of consumer
2094 grievances against provider organizations registered under section 10 of chapter 12C including,
2095 but not limited to, complaint and appeals processes regarding health care personnel, facilities,
2096 treatment quality, restrictions on patient choice and denials of services or treatments.

2097 SECTION 81. Said section 217 of said chapter 111, as so appearing, is hereby further
2098 amended by striking out, in lines 48 and 49, the words “the division of health care finance and
2099 policy pursuant to section 24 of chapter 118G” and inserting in place thereof the following
2100 words:- the institute of health care finance and policy.

2101 SECTION 82. Subsection (b) of said section 217 of said chapter 111, as so appearing, is
2102 hereby amended by adding the following 2 sentences:-

2103 The commissioner shall establish an external review process for the review of grievances
2104 submitted by or on behalf of patients of provider organizations registered under section 10 of
2105 chapter 12C and shall specify the maximum amount of time for the completion of a
2106 determination and review after a grievance is submitted. The department shall establish
2107 expedited review procedures applicable to emergency situations.

2108 SECTION 83. Said chapter 111 is hereby further amended by adding the following 3
2109 sections:-

2110 Section 225. (a) For the purposes of this section, the following words shall have the
2111 following meanings:—

2112 “Anatomic pathology service”, histopathology, surgical pathology, cytopathology,
2113 hematology, subcellular pathology, molecular pathology and blood-banking services performed
2114 by a pathologist.

2115 “Charge”, the uniform price for specific services within a revenue center of a hospital.

2116 “Cytopathology”, the examination of cells from the following:

2117 (i) fluids;

2118 (ii) aspirates;

2119 (iii) washings;

2120 (iv) brushings; or

2121 (v) smears, including the pap test examination performed by a physician or under
2122 the supervision of a physician.

2123 “Hematology”, the microscopic evaluation of bone marrow aspirates and biopsies
2124 performed by a physician or under the supervision of a physician, and peripheral blood smears
2125 when the attending or treating physician or technologist requests that a blood smear be reviewed
2126 by a pathologist.

2127 “Histopathology” or “surgical pathology”, the gross and microscopic examination of
2128 organ tissue performed by a physician or under the supervision of a physician.

2129 “Patient”, any natural person receiving health care services.

2130 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
2131 patient for a charge.

2132 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX
2133 programs, other governmental payers, insurance companies, health maintenance organizations
2134 and nonprofit hospital service corporations. Third party payer shall not include a purchaser
2135 responsible for payment for health care services rendered by a hospital, either to the purchaser or
2136 to the hospital.

2137 (b) A clinical laboratory or physician providing anatomic pathology services for patients
2138 in the commonwealth shall present or cause to be presented a claim, bill or demand for payment
2139 for these services only to the following:

2140 (i) the patient directly;

2141 (ii) the responsible insurer or other third-party payer;

2142 (iii) the hospital, public health clinic or nonprofit health clinic ordering such
2143 services;

2144 (iv) the referral laboratory or a physician’s office laboratory when the physician
2145 of such laboratory performs the anatomic pathology service; or

2146 (v) the governmental agency or its specified public or private agent, agency or
2147 organization on behalf of the recipient of the services.

2148 (c) Except as provided under this section, no licensed practitioner shall, directly or
2149 indirectly, charge, bill or otherwise solicit payment for anatomic pathology services unless the

2150 services were rendered personally by the licensed practitioner or under the licensed practitioner's
2151 direct supervision under section 353 of the Public Health Service Act, 42 U.S.C. § 263a.

2152 (d) No patient, insurer, third party payer, hospital, public health clinic or non-profit health
2153 clinic shall be required to reimburse any licensed practitioner for charges or claims submitted in
2154 violation of this section.

2155 (e) Nothing in this section shall be construed to mandate the assignment of benefits for
2156 anatomic pathology services.

2157 (f) Nothing in this section shall prohibit billing between laboratories for anatomic
2158 pathology services in instances where a sample must be sent to another specialist. Nothing in this
2159 section shall authorize a physician's office laboratory to bill for anatomic pathology services
2160 when the physician of such laboratory has not performed the anatomic pathology service.

2161 (g) The board of registration in medicine may revoke, suspend or deny renewal of the
2162 license of a practitioner who violates this section.

2163 Section 226. (a) Prior to an admission, procedure or service and upon request by a patient
2164 or prospective patient, a health care provider shall, within 2 working days, disclose the allowed
2165 amount or charge of the admission, procedure or service, including the amount for any facility
2166 fees required; provided, however, that if a health care provider is unable to quote a specific
2167 amount in advance due to the health care provider's inability to predict the specific treatment or
2168 diagnostic code, the health care provider shall disclose the estimated maximum allowed amount
2169 or charge for a proposed admission, procedure or service, including the amount for any facility
2170 fees required.

2171 (b) If a patient or prospective patient is covered by a health plan, a health care provider
2172 who participates as a network provider shall, upon request of a patient or prospective patient,
2173 provide notice of , based on the information available to the provider at the time of the request,
2174 sufficient information regarding the proposed admission, procedure or service for the patient or
2175 prospective patient to use and the applicable toll-free telephone number and website of the health
2176 plan established to disclose co-insurance, copayment and deductibles, under clause (3) of
2177 subsection (a) of section 6 of chapter 1760. A health care provider may assist a patient or
2178 prospective patient in using the health plan’s toll-free number and website.

2179 (c) The commissioner shall, in consultation with the board of registration in medicine,
2180 promulgate regulations to enforce this section. The commissioner may impose a fine of up to
2181 \$1000 for each violation of this section. A health care provider aggrieved by the issuance of a
2182 fine under this section may, within 21 days of receiving notification of the commissioner’s
2183 decision to impose such fine, request an adjudicatory hearing under chapter 30A.

2184 Section 227. (a) As used in this section the following terms shall, unless the context
2185 clearly requires otherwise, have the following meanings:

2186 “Appropriate”, consistent with applicable legal, health and professional standards, the
2187 patient’s clinical and other circumstances and the patient’s reasonably known wishes and beliefs.

2188 “Attending health care practitioner”, a physician or nurse practitioner who has primary
2189 responsibility for the care and treatment of the patient; provided that if more than 1 physician or
2190 nurse practitioner share that responsibility, each of them shall have a responsibility under this
2191 section, unless they agree to assign that responsibility to 1 of them.

2192 “Palliative care”, a health care treatment, including interdisciplinary end-of-life care, and
2193 consultation with patients and family members, to prevent or relieve pain and suffering and to
2194 enhance the patient’s quality of life, including hospice care.

2195 “Terminal illness or condition”, an illness or condition which can reasonably be expected
2196 to cause death within 6 months, whether or not treatment is provided.

2197 (b) The commissioner shall adopt regulations requiring each licensed hospital, skilled
2198 nursing facility, health center or assisted living facility to distribute to appropriate patients in its
2199 care information regarding the availability of palliative care and end-of-life options.

2200 (c) If a patient is diagnosed with a terminal illness or condition, the patient’s attending
2201 health care practitioner shall offer to provide the patient with information and counseling
2202 regarding palliative care and end-of-life options appropriate to the patient, including, but not
2203 limited to: (i) the range of options appropriate to the patient; (ii) the prognosis, risks and benefits
2204 of the various options; and (iii) the patient’s legal rights to comprehensive pain and symptom
2205 management at the end-of-life. The information and counseling may be provided orally or in
2206 writing. Where the patient lacks capacity to reasonably understand and make informed choices
2207 relating to palliative care, the attending health care practitioner shall provide information and
2208 counseling under this section to a person with authority to make health care decisions for the
2209 patient. The attending health care practitioner may arrange for information and counseling under
2210 this section to be provided by another professionally qualified individual.

2211 If the attending health care practitioner is not willing to provide the patient with
2212 information and counseling under this section, the attending health care practitioner shall arrange

2213 for another physician or nurse practitioner to do so or shall refer or transfer the patient to another
2214 physician or nurse practitioner willing to do so.

2215 (d) The department shall consult with the Hospice and Palliative Care Federation of
2216 Massachusetts in developing educational documents, rules and regulations related to this section.

2217 SECTION 84. Section 1 of chapter 111K of the General Laws, as appearing in the 2010
2218 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words “established by
2219 section 18 of chapter 118G”.

2220 SECTION 85. Section 10 of said chapter 111K, as so appearing, is hereby amended by
2221 striking out, in line 2, the word “division”, the second time it appears, and inserting in place
2222 thereof the following word:- institute.

2223 SECTION 86. Section 3 of chapter 111M of the General Laws, as so appearing, is hereby
2224 amended by striking out, in lines 10 and 11, the word “division” and inserting in place thereof, in
2225 each instance, the following word:- institute.

2226 SECTION 87. The first paragraph of section 2 of chapter 112 of the General Laws, as so
2227 appearing, is hereby amended by inserting after the second sentence the following 2 sentences:-
2228 The board shall require, as a standard of eligibility for licensure, that applicants demonstrate
2229 proficiency in the use of computerized physician order entry, e-prescribing, electronic health
2230 records and other forms of health information technology, as determined by the board; provided,
2231 that proficiency, at a minimum, shall mean that applicants demonstrate the skills to comply with
2232 the “meaningful use” requirements under 45 C.F.R. Part 170.

2233 SECTION 88. Chapter 112 of the General Laws, is hereby amended by inserting, after
2234 section 2C, the following section:-

2235 Section 2D. No physician shall enter into a contract or agreement, which creates or
2236 establishes a partnership, employment or any other form of professional relationship that
2237 prohibits a physician from providing testimony in an administrative or judicial hearing, including
2238 cases of medical malpractice.

2239 SECTION 88A. Section 5 of said chapter 112, as so appearing, is hereby amended by
2240 striking out paragraphs 6 to 8, inclusive, and inserting in place thereof the following 4
2241 paragraphs: -

2242 The board shall collect the following information reported to it to create individual
2243 profiles on licensees and former licensees, in a format created by the board that shall be available
2244 for dissemination to the public:

2245 (a) a description of any criminal convictions for felonies and serious misdemeanors as
2246 determined by the board; provided, that for the purposes of this subsection, a person shall be
2247 deemed to be convicted of a crime if the person pleaded guilty or if the person was found or
2248 adjudged guilty by a court of competent jurisdiction;

2249 (b) a description of any charges for felonies and serious misdemeanors as determined by
2250 the board to which a physician pleads nolo contendere or where sufficient facts of guilt were
2251 found and the matter was continued without a finding by a court of competent jurisdiction;

2252 (c) a description of any final board disciplinary actions and a copy of any original board
2253 disciplinary orders;

2254 (d) a description of any final disciplinary actions by licensing boards in other states;

2255 (e) a description of revocation or involuntary restriction of privileges by a hospital, clinic
2256 or nursing home under chapter 111 or of any employer who employs physicians licensed by the
2257 board for the purpose of engaging in the practice of medicine in the commonwealth, for reasons
2258 related to competence or character that have been taken by the hospital, clinic or nursing home or
2259 employer who employs physicians licensed by the board for to engage in the practice of
2260 medicine in the commonwealth governing body or any other official of the hospital, clinic or
2261 nursing home or employer who employs physicians licensed by the board to engage in the
2262 practice of medicine in the commonwealth after procedural due process has been afforded, or
2263 the resignation from or nonrenewal of medical staff membership or the restriction of privileges at
2264 a hospital, clinic or nursing home or employer who employs physicians licensed by the board to
2265 engage in the practice of medicine in the commonwealth taken in lieu of or in settlement of a
2266 pending disciplinary case related to competence or character in that hospital, clinic or nursing
2267 home or of any employer who employs physicians licensed by the board to engage in the practice
2268 of medicine or employer who employs physicians licensed by the board for the purpose of
2269 engaging in the practice of medicine in the commonwealth;

2270 (f) all medical malpractice court judgments and all medical malpractice arbitration
2271 awards in which a payment is awarded to a complaining party and all settlements of medical
2272 malpractice claims in which a payment is made to a complaining party; provided that
2273 dispositions of paid claims shall be reported in a minimum of 3 graduated categories indicating
2274 the level of significance of the award or settlement; provided, further that information concerning
2275 paid medical malpractice claims shall be put in context by comparing an individual licensee's
2276 medical malpractice judgment awards and settlements to the experience of other physicians

2277 within the same specialty; provided, further that information concerning all settlements shall be
2278 accompanied by the following statement: “Settlement of a claim may occur for a variety of
2279 reasons which do not necessarily reflect negatively on the professional competence or conduct of
2280 the physician. A payment in settlement of a medical malpractice action or claim should not be
2281 construed as creating a presumption that medical malpractice has occurred.”; provided further
2282 that nothing in this subsection shall be construed to limit or prevent the board from providing
2283 further explanatory information regarding the significance of categories in which settlements are
2284 reported; provided, further that pending malpractice claims shall not be disclosed by the board to
2285 the public; provided, further that nothing in this section shall be construed to prevent the board
2286 from investigating and disciplining a licensee on the basis of medical malpractice claims that are
2287 pending;

2288 (g) names of medical schools and dates of graduation;

2289 (h) graduate medical education;

2290 (i) specialty board certification;

2291 (j) number of years in practice;

2292 (k) names of the hospitals where the licensee has privileges;

2293 (l) appointments to medical school faculties and indication as to whether a licensee has a
2294 responsibility for graduate medical education within the most recent 10 years;

2295 (m) information regarding publications in peer-reviewed medical literature within the
2296 most recent 10 years;

2297 (n) information regarding professional or community service activities and awards;

2298 (o) the location of the licensee's primary practice setting;

2299 (p) the identification of any translating services that may be available at the licensee's
2300 primary practice location; and

2301 (q) an indication of whether the licensee participates in the Medicaid program.

2302 The board shall provide individual licensees with a copy of their profiles prior to release
2303 to the public. A licensee shall be provided a reasonable time to correct factual inaccuracies that
2304 appear in such profile.

2305 A physician may elect to have the physician's profile omit certain information provided
2306 under clauses (l) to (n), inclusive, concerning academic appointments and teaching
2307 responsibilities, publication in peer-reviewed journals and professional and community service
2308 awards. In collecting information for such profiles and in disseminating the same, the board shall
2309 inform physicians that they may choose not to provide such information required under said
2310 clauses (l) to (n), inclusive.

2311 For physicians who are no longer licensed by the board, the board shall continue to make
2312 available the profiles of such physicians, except for those who are known by the board to be
2313 deceased. The board shall maintain the information contained in the profiles of physicians no
2314 longer licensed by the board as of the date the physician was last licensed, and include on the
2315 profile a notice that the information is current only to that date.

2316 SECTION 88B. Said chapter 112 is hereby amended by striking out section 12B and
2317 inserting in place thereof the following section:-

2318 Section 12B. No physician duly registered under sections 2, 2A, 9, 9A or 9B, no
2319 physician assistant duly registered under section 9I or the physician assistant's employing or
2320 supervising physician, no nurse duly registered or licensed under sections 74, 74A or 76, no
2321 pharmacist duly registered under section 24, no pharmacy technician duly registered under
2322 section 24C, no dentist duly registered under sections 45 or 45A, no psychologist duly licensed
2323 under sections 118 through 129, no social worker duly licensed under sections 130 through 137,
2324 no marriage and family therapist or mental health counselor duly licensed under sections 165
2325 through 171, and no radiologic technologist duly licensed under section 5L of chapter 111, or
2326 resident in another state, the District of Columbia or a province of Canada, and duly registered or
2327 licensed in such state, district or province, who, in good faith, as a volunteer and without fee,
2328 renders emergency care or treatment, other than in the ordinary course of said person's practice,
2329 shall be liable in a suit for damages as a result of said person's acts or omissions; provided,
2330 further, that said person shall not be liable to a hospital for its expenses if, under such emergency
2331 conditions, said person orders a person hospitalized or causes admission.

2332 SECTION 88C. Section 9C of said chapter 112, as so appearing, is hereby amended by
2333 striking out the definition of “physician assistant” and inserting in place thereof the following
2334 definition:-

2335 “Physician assistant”, a person who is duly registered and licensed by the board.

2336 SECTION 88D. The first paragraph of section 9E of said chapter 112, as so appearing, is
2337 hereby amended by striking out the third sentence.

2338 SECTION 88E. The third paragraph of said section 9E of said chapter 112, as so
2339 appearing, is hereby further amended by striking out the second sentence.

2340 SECTION 89. Said chapter 112 is hereby further amended by inserting after section 80H
2341 the following section:-

2342 Section 80I. When a law or rule requires a signature, certification, stamp, verification,
2343 affidavit or endorsement by a physician, when relating to physical, behavioral, substance use
2344 disorder or mental health, that requirement may be fulfilled by a nurse practitioner practicing
2345 under section 80B. Nothing in this section shall be construed to expand the scope of practice of
2346 nurse practitioners. This section shall not be construed to preclude the development of mutually
2347 agreed upon guidelines between the nurse practitioner and supervising physician under section
2348 80E.

2349 SECTION 90. Chapter 118E of the General Laws, as so appearing, is hereby amended by
2350 striking out section 8 and inserting in place thereof the following section:-

2351 Section 8. As used in this chapter the following terms and phrases shall, unless the
2352 context clearly requires otherwise, have the following meanings:

2353 “Actual costs”, all direct and indirect costs incurred by a hospital or a community health
2354 center in providing medically necessary care and treatment to its patients, determined in
2355 accordance with generally accepted accounting principles.

2356 “Acute hospital”, the teaching hospital of the University of Massachusetts Medical
2357 School and any hospital licensed under section 51 of chapter 111 and which contains a majority
2358 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of
2359 public health.

2360 “Case mix”, the description and categorization of a hospital’s patient population
2361 according to criteria approved by the institute including, but not limited to, primary and
2362 secondary diagnoses, primary and secondary procedures, illness severity, patient age and source
2363 of payment.

2364 “Charge”, the uniform price for specific services within a revenue center of a hospital.

2365 “Child”, a person who is under 18 years of age.

2366 “Commissioner”, the commissioner of medical assistance or the secretary of elder affairs,
2367 as appropriate.

2368 “Community health centers”, health centers operating in conformance with Section 330
2369 of United States Public Law 95-626 and shall include all community health centers which file
2370 cost reports as requested by the institute.

2371 “Comprehensive cancer center”, the hospital of any institution so designated by the
2372 national cancer institute under the authority of 42 USC sections 408(a) and 408(b) organized
2373 solely for the treatment of cancer, and offered exemption from the Medicare diagnosis related
2374 group payment system under 42 C.F.R. 405.475(f).

2375 “Department”, the department of elder affairs.

2376 “Disproportionate share hospital”, an acute hospital that exhibits a payer mix where a
2377 minimum of 63 per cent of the acute hospital’s gross patient service revenue is attributable to
2378 Title XVIII and Title XIX of the federal Social Security Act other government payers and free
2379 care.

2380 “Division”, the division of medical assistance within the executive office of health and
2381 human services; but for the purposes of sections 9 to 52, inclusive, a reference to the word
2382 “division” shall mean the department of elder affairs, whenever appropriate.

2383 “Emergency medical condition”, a medical condition, whether physical, behavioral,
2384 related to a substance use disorder or mental, manifesting itself by symptoms of sufficient
2385 severity, including severe pain, that the absence of prompt medical attention could reasonably be
2386 expected by a prudent layperson who possesses an average knowledge of health and medicine, to
2387 result in placing the health of the person or another person in serious jeopardy, serious
2388 impairment to body function, or serious dysfunction of any body organ or part, or, with respect
2389 to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42
2390 U.S.C. section 1395dd(e)(1)(B).

2391 “Emergency services”, medically necessary health care services provided to an individual
2392 with an emergency medical condition.

2393 “Employee”, a person who performs services primarily in the commonwealth for
2394 remuneration for a commonwealth employer; provided, that “employee” shall not include a
2395 person who is self-employed.

2396 “Employer”, an employer as defined in section 1 of chapter 151A.

2397 “Enrollee”, a person who becomes a member of an insurance program of the division
2398 either individually or as a member of a family.

2399 “Executive office”, the executive office of health and human services.

2400 “Financial requirements”, a hospital’s requirement for revenue which shall include, but
2401 not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of
2402 depreciation of plant and equipment and the reasonable costs associated with changes in medical
2403 practice and technology.

2404 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
2405 ends in the calendar year by which it is identified.

2406 “Free care”, the following medically necessary services provided to individuals
2407 determined to be financially unable to pay for their care, in whole or in part, under applicable
2408 regulations of the executive office: (1) services provided by acute hospitals; (2) services
2409 provided by community health centers; and (3) patients in situations of medical hardship in
2410 which major expenditures for health care have depleted or can reasonably be expected to deplete
2411 the financial resources of the individual to the extent that medical services cannot be paid, as
2412 determined by regulations of the executive office.

2413 “General health supplies, care or rehabilitative services and accommodations”, all
2414 supplies, care and services of medical, behavioral, substance use disorder, mental, optometric,
2415 dental, surgical, chiropractic, podiatric, psychiatric, therapeutic, diagnostic, rehabilitative,
2416 supportive or geriatric nature, including inpatient and outpatient hospital care and services, and
2417 accommodations in hospitals, sanatoria, infirmaries, convalescent and nursing homes, retirement
2418 homes, facilities established, licensed or approved under chapter 111B and providing services of
2419 a medical or health-related nature, and similar institutions including those providing treatment,
2420 training, instruction and care of children and adults; provided, however, that rehabilitative

2421 service shall include only rehabilitative services of a medical or health-related nature which are
2422 eligible for reimbursement under Title XIX of the Social Security Act.

2423 “Governmental mandate”, a state or federal statutory requirement, administrative rule,
2424 regulation, assessment, executive order, judicial order or other governmental requirement that
2425 directly or indirectly imposes an obligation and associated compliance cost upon a provider to
2426 take an action or to refrain from taking an action in order to fulfill the provider’s contractual duty
2427 to a procuring governmental unit.

2428 “Governmental unit”, the commonwealth, any department, agency board or commission
2429 of the commonwealth and any political subdivision of the commonwealth.

2430 “Gross patient service revenue”, the total dollar amount of a hospital’s charges for
2431 services rendered in a fiscal year.

2432 “Health care services”, supplies, care and services of medical, behavioral, substance use
2433 disorder, mental, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic,
2434 diagnostic, preventative, rehabilitative, supportive or geriatric nature including, but not limited
2435 to, inpatient and outpatient acute hospital care and services; services provided by a community
2436 health center or by a sanatorium, as included in the definition of “hospital” in Title XVIII of the
2437 federal Social Security Act, and treatment and care compatible with such services or by a health
2438 maintenance organization.

2439 “Health insurance company”, a company as defined in section 1 of chapter 175 which
2440 engages in the business of health insurance.

2441 “Health insurance plan”, the Medicare program or an individual or group contract or
2442 other plan providing coverage of health care services and which is issued by a health insurance
2443 company, a hospital service corporation, a medical service corporation or a health maintenance
2444 organization.

2445 “Health maintenance organization”, a company which provides or arranges for the
2446 provision of health care services to enrolled members in exchange primarily for a prepaid per
2447 capita or aggregate fixed sum as further defined in section 1 of chapter 176G.

2448 “Hospital”, a hospital licensed under section 51 of chapter 111, the teaching hospital of
2449 the University of Massachusetts Medical School and any psychiatric facility licensed under
2450 section 19 of chapter 19.

2451 “Institution”, a licensed hospital, nursing home or public medical institution that meets
2452 the requirements of the secretary.

2453 “Medicaid”, the jointly funded state and federal medical assistance program established
2454 under Title XIX under section 9 of this chapter.

2455 “Medical assistance”, payment by the department, or its agent, or any predecessor or
2456 successor agency, of all or part of the cost of the medical care and services provided to recipients
2457 of any program established under this chapter, but not including benefits provided under section
2458 9A.

2459 “Medical assistance program”, the Medicaid program, the Veterans Administration health
2460 and hospital programs and any other medical assistance program operated by a governmental
2461 unit for persons categorically eligible for such program.

2462 “Medically necessary services”, medically necessary inpatient and outpatient services as
2463 mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall
2464 not include: (1) non-medical services, such as social, educational and vocational services; (2)
2465 cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and
2466 consultations; (5) court testimony; (6) research or the provision of experimental or unproven
2467 procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-
2468 surgery hormone therapy; and (7) the provision of whole blood; and provided, however, that
2469 administrative and processing costs associated with the provision of blood and its derivatives
2470 shall be payable.

2471 “Medical benefits”, benefits provided under section 9A.

2472 “Medicare program”, the medical insurance program established by Title XVIII of the
2473 Social Security Act.

2474 “Non-acute hospital”, a hospital which is not an acute hospital.

2475 “Patient”, a natural person receiving health care services from a hospital.

2476 “Pediatric hospital”, an acute care hospital which limits services primarily to children and
2477 which qualifies as exempt from the Medicare Prospective Payment system regulations.

2478 “Pediatric specialty unit”, a pediatric unit of an acute care hospital in which the ratio of
2479 licensed pediatric beds to total licensed hospital beds as of July 1, 1994, exceeded 0.20. In
2480 calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds,
2481 and the total of all licensed hospital beds shall include the total of all licensed acute care hospital

2482 beds, consistent with Medicare’s acute care hospital reimbursement methodology as put forth in
2483 the Provider Reimbursement Manual Part 1, Section 2405.3G.

2484 “Person”, an individual who resides in the commonwealth or any individual residing
2485 outside the commonwealth who is deemed to be a resident of the commonwealth under Title
2486 XIX.

2487 “Provider”, an institution, agency, individual or other legal entity qualified under the laws
2488 of the commonwealth to perform the medical care or services for which medical assistance and
2489 medical benefits are available under this chapter.

2490 “Public medical institution”, a medical institution supported in whole or in part by public
2491 funds, either federal, state or municipal staffed by professional, medical and nursing personnel
2492 and providing medical care, in accordance with standards established through licensing or
2493 approval by the department of public health.

2494 “Publicly aided patient”, a person who receives hospital care and services for which a
2495 governmental unit is liable, in whole or in part, under a statutory program of public assistance.

2496 “Purchaser”, a natural person responsible for payment for health care services rendered
2497 by a hospital.

2498 “Reside”, to occupy an established place of abode with no present intention of definite
2499 and early removal, but not necessarily with the intention of remaining permanently, but in no
2500 event shall the word “reside” be construed more restrictively or less restrictively than as defined
2501 by the Secretary under Title XIX.

2502 “Resident”, a person living in the commonwealth, as defined by the executive office by
2503 regulation; provided, however, that such regulation shall not define a resident as a person who
2504 moved into the commonwealth for the sole purpose of securing health insurance under this
2505 chapter; and provided, further that confinement of a person in a nursing home, hospital or other
2506 medical institution shall not in and of itself, suffice to qualify such person as a resident.

2507 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
2508 patient for a charge.

2509 “Secretary”, the Secretary of the United States Department of Health and Human
2510 Services, except as that term is used in section 2 of this chapter.

2511 “Self-employed”, a person who, at common law, is not considered to be an employee and
2512 whose primary source of income is derived from the pursuit of a bona fide business.

2513 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
2514 business, which is not a health insurance plan, and in which the business is liable for the actual
2515 costs of the health care services provided by the plan and administrative costs.

2516 “Social service program”, a social, mental health, developmental disabilities, habilitative,
2517 rehabilitative, substance abuse, residential care, adult or adolescent day care, vocational,
2518 employment and training or elder service program or accommodations, purchased by a
2519 governmental unit or political subdivision of the executive office of health and human services,
2520 but excluding any program, service or accommodation that: (a) is reimbursable under a Medicaid
2521 waiver granted under section 1115 of Title XI of the Social Security Act; or (b) is funded
2522 exclusively by a federal grant.

2523 “Social service program provider”, a provider of social service programs in the
2524 commonwealth.

2525 “Sole community provider”, any acute hospital which qualifies as a sole community
2526 provider under Medicare regulations or under regulations promulgated by the executive office,
2527 which regulations shall consider factors including, but not limited to, isolated location, weather
2528 conditions, travel conditions, percentage of Medicare, Medicaid and free care provided and the
2529 absence of other reasonably accessible hospitals in the area; provided, that such hospitals shall
2530 include those which are located more than 25 miles from other such hospitals in the
2531 commonwealth and which provide services for at least 60 per cent of their primary service area.

2532 “Specialty hospital”, an acute hospital which qualifies for an exemption from the
2533 Medicare prospective payment system regulations or an acute hospital which limits its
2534 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to
2535 children or patients under obstetrical care.

2536 “State institution”, a hospital, sanatorium, infirmary, clinic and other such facility owned,
2537 operated or administered by the commonwealth, which furnishes general health supplies, care or
2538 rehabilitative services and accommodations.

2539 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX
2540 programs, other governmental payers, insurance companies, health maintenance organizations
2541 and nonprofit hospital service corporations; provided, however, that “third party payer” shall not
2542 include a purchaser responsible for payment for health care services rendered by a hospital,
2543 either to the purchaser or to the hospital.

2544 “Title XIX”, Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq. or any
2545 successor thereto.

2546 “Title XXI”, Title XXI of the Social Security Act, 42 USC 1397 et seq. or any successor
2547 thereto.

2548 SECTION 91. Section 9C of said chapter 118E, as so appearing, is hereby amended by
2549 striking out, in line 145, the words “established by subsection (c) of section 18 of chapter 118G”.

2550 SECTION 91A. Said chapter 118E of the General Laws is hereby amended by inserting
2551 after section 9E the following section:-

2552 Section 9F. (a) As used in this section the following words shall, unless the context
2553 clearly requires otherwise, have the following meanings:-

2554 “Dual eligible” or “dually eligible person”, any person age 21 or older and under age 65
2555 who is enrolled in both Medicare and MassHealth.

2556 “Integrated care organization” or “ICO”, a comprehensive network of medical, health
2557 care and long-term services and supports providers that integrates all components of care, either
2558 directly or through subcontracts and has been contracted with by the executive office and
2559 designated an ICO to provide services to dually eligible individuals under this section.

2560 (b) Members of the MassHealth dual eligible pilot program on ICOs or any successor
2561 program integrating care for dual eligible persons shall be provided an independent community
2562 care coordinator by the ICO or successor organization, who shall be a participant in the
2563 member’s care team. The community care coordinator shall assist in the development of a long-
2564 term support and services care plan. The community care coordinator shall:

2565 (i) participate in initial and ongoing assessments of the health and functional status of the
2566 member, including determining appropriateness for long-term care support and services, either in
2567 the form of institutional or community-based care plans and related service packages necessary
2568 to improve or maintain enrollee health and functional status;

2569 (ii) arrange and, with the agreement of the member and the care team, coordinate the
2570 provision of appropriate institutional and community long-term supports and services, including
2571 assistance with the activities of daily living and instrumental activities of daily living, housing,
2572 home-delivered meals, transportation and under specific conditions or circumstances established
2573 by the ICO or successor organization, authorize a range and amount of community-based
2574 services; and

2575 (iii) monitor the appropriate provision and functional outcomes of community long term
2576 care services, according to the service plan as considered appropriate by the member and the care
2577 team; and track member satisfaction and the appropriate provision and functional outcomes of
2578 community long-term care services, according to the service plan as considered appropriate by
2579 the member and the care team.

2580 (c) The ICO or successor organization shall not have a direct or indirect financial
2581 ownership interest in an entity that serves as an independent care coordinator. Providers of
2582 institutional or community based long-term services and supports on a compensated basis shall
2583 not function as an independent care coordinator; provided, however, that the secretary of the
2584 executive office of health and human services may grant a waiver of this restriction upon a
2585 finding that public necessity and convenience require such a waiver. An individual who becomes
2586 dually eligible after the age of 60 shall receive independent care coordination services under

2587 section 4B of chapter 19A. For the purposes of this section, an organization compensated to
2588 provide only evaluation, assessment, coordination and fiscal intermediary services shall not be
2589 considered a provider of long-term services and supports.

2590 SECTION 92. Section 12 of said chapter 118E, as so appearing, is hereby amended by
2591 striking out, in line 11, the word “division” and inserting in place thereof the following word:-
2592 institute.

2593 SECTION 93. Section 13 of said chapter 118E, as so appearing, is hereby amended by
2594 striking out, in lines 3 and 4, the words “division of health care finance and policy established by
2595 chapter one hundred and eighteen G, which shall be called the “division” only” and inserting in
2596 place thereof the following words:- executive office of health and human services, which shall be
2597 called the “executive office” only or by a governmental unit designated by the executive office.

2598 SECTION 94. Said section 13 of said chapter 118E, as so appearing, is hereby further
2599 amended by striking out, in lines, 9, 15, 18, 20, 22, and 23 the word “division” and inserting in
2600 place thereof, in each instance, the following words:- executive office.

2601 SECTION 95. Said section 13 of said chapter 118E, as so appearing, is hereby further
2602 amended by striking out, in line 25, the word “division” and inserting in place thereof the
2603 following words:- institute of health care finance and policy.

2604 SECTION 96. Section 13B of said chapter 118E, as so appearing, is hereby further
2605 amended by striking out, in lines 11 and 12, the words “the Massachusetts health care quality and
2606 cost council, established under section 16K of chapter 6A and”.

2607 SECTION 97. Said chapter 118E is hereby amended by inserting after section 13B the
2608 following 10 sections:-

2609 Section 13C. The secretary of the executive office shall establish rates of payment for
2610 health care services; provided, that the secretary may designate another governmental unit to
2611 perform such ratemaking functions. The secretary of the executive office shall have the
2612 responsibility for establishing rates to be paid to providers for health care services by
2613 governmental units, including the division of industrial accidents. The rates shall be adequate to
2614 meet the costs incurred by efficiently and economically operated facilities providing care and
2615 services in conformity with applicable state and federal laws and regulations and quality and
2616 safety standards and which are within the financial capacity of the commonwealth.
2617 Notwithstanding any general or special law or rule or regulation to the contrary, the secretary of
2618 the executive office shall have the responsibility for establishing fair and adequate charges to be
2619 used by state institutions for general health supplies, care and rehabilitative services and
2620 accommodations, which charges shall be based on the actual costs of the state institution
2621 reasonably related, in the circumstances of each institution, to the efficient production of the
2622 services in the institution and shall also have sole responsibility for determining rates paid for
2623 educational assessments conducted or performed by psychologists and trained, certified
2624 educational personnel under the tenth paragraph of section 3 of chapter 71B.

2625 The secretary of the executive office shall have the responsibility for establishing rates of
2626 payment for social service programs which are reasonable and adequate to meet the costs which
2627 are incurred by efficiently and economically operated social service program providers in
2628 providing social service programs in conformity with federal and state law, regulations and
2629 quality and safety standards; provided, that the secretary may designate another governmental

2630 unit to perform such ratemaking functions. When establishing rates of payment for social service
2631 programs, the secretary of the executive office shall adjust rates to take into account factors,
2632 including, but not limited to: (a) the reasonable cost to social service program providers of any
2633 existing or new governmental mandate that has been enacted, promulgated or imposed by any
2634 governmental unit or federal governmental authority; (b) a cost adjustment factor to reflect
2635 changes in reasonable costs of goods and services of social service programs including those
2636 attributed to inflation; and (c) geographic differences in wages, benefits, housing and real estate
2637 costs in each metropolitan statistical area of the commonwealth, and in any city or town therein
2638 where such costs are substantially higher than the average cost within that area as a whole. The
2639 secretary of the executive office shall not consider any of the resources specified in section 13G
2640 when establishing, reviewing or approving rates of payment for social service programs.

2641 Section 13D. The executive office, or a governmental unit designated to perform
2642 ratemaking functions by the executive office, (1) shall determine, after public hearing, at least
2643 annually for institutional providers, and at least biennially for non-institutional providers, the
2644 rates to be paid by each governmental unit to providers of health care services and social service
2645 programs; provided, however, that for the purposes of this section, social service program
2646 providers shall be treated as non-institutional providers; (2) shall determine, after public hearing,
2647 at least annually, the rates to be charged by each state institution for general health supplies, care
2648 or rehabilitative services and accommodations; (3) shall certify to each affected governmental
2649 unit the rates so determined; (4) shall determine, after public hearing, at least annually, and
2650 certify to the division of industrial accidents of the department of labor and industries, rates of
2651 payment for general health supplies, care or rehabilitative services and accommodations, which
2652 rates shall be paid for services under chapter 152; (5) shall, upon request of the division of

2653 insurance, assist the division of insurance in the performance of its duties as set forth in section 4
2654 of chapter 176B; and (6) may establish fair and reasonable classifications upon which any rates
2655 may be based for rest homes, nursing homes and convalescent homes; provided, however, that
2656 the executive office shall not cause a decrease in a rate or add a penalty to a rate because such
2657 home has an equity position which is less than 0.

2658 Such rates for nursing homes and rest homes, as defined under section 71 of chapter 11,
2659 shall be established as of October 1 of each year. In setting such rates, the executive office shall
2660 use as base year costs for rate determination purposes the reported costs of the calendar year not
2661 more than 4 years prior to the current rate year, adjusted for reasonableness and to incorporate
2662 any audit findings applicable to said base year costs. In any appeal of rates under section 13E,
2663 the petitioner shall not be permitted to introduce into the records of such an appeal evidence of
2664 costs for any year other than the base year used to establish the rate. Notwithstanding any other
2665 general or special law or regulation to the contrary, except as provided in this chapter, each
2666 governmental unit shall pay to a provider of services and each state institution shall charge as a
2667 provider of health care services, as the case may be, the rates for general health supplies, care
2668 and rehabilitative services and accommodations determined and certified by the executive office.
2669 In establishing rates of payment to providers of services, the executive office shall control rate
2670 increases and shall impose such methods and standards as are necessary to ensure reimbursement
2671 for those costs which must be incurred by efficiently and economically operated facilities and
2672 providers. Such methods and standards may include, but shall not be limited to, the following:
2673 peer group cost analyses; ceilings on capital and operating costs; productivity standards; caps or
2674 other limitations on the utilization of temporary nursing or other personnel services; use of
2675 national or regional indices to measure increases or decreases in reasonable costs; limits on

2676 administrative costs associated with the use of management companies; the availability of
2677 discounts for large volume purchasers; the revision of existing historical cost bases, where
2678 applicable, to reflect norms or models of efficient service delivery; and other means to encourage
2679 the cost-efficient delivery of services. Rates produced using these methods and standards shall be
2680 in conformance with Title XIX, including the upper limit on provider payments.

2681 In determining rates to be paid by governmental units to providers of services, the
2682 executive office shall include as an operating expense of a provider of services any contribution
2683 made in lieu of taxes by such provider of services to a city or town and shall establish by
2684 regulation those expenses treated as business deductions under the Internal Revenue Code, which
2685 shall be included as allowable operating expenses in determining rates of reimbursement. Except
2686 for ceilings or maximum rates of reimbursement, which are determined in accordance with rate
2687 determination methods imposed on nursing homes, any ceiling or maximum imposed by the
2688 executive office upon the rate of reimbursement to be paid to rest homes shall reflect the actual
2689 costs of rest home providers and shall not prevent any such rest home provider from receiving
2690 full payment for costs necessarily incurred in the provision of services in compliance with
2691 federal or state regulations and requirements.

2692 In determining rates to be paid by governmental units to acute-care hospitals, as defined
2693 in section 25B of chapter 111, and any hospital or separate unit of a hospital that provides acute
2694 psychiatric services, as defined in said section 25B, the executive office shall include as an
2695 operating expense the reasonable cost of providing competent interpreter services as required by
2696 section 25J of said chapter 111 or section 23A of chapter 123.

2697 No hospital shall receive reimbursement or payment from any governmental unit for
2698 amounts paid to employees, as salary, or to consultant or other firms, as fees, where the primary
2699 responsibility of the employees or consultants is, either directly or indirectly, to persuade or seek
2700 to persuade the employees of the hospital to support or oppose unionization. Attorney's fees for
2701 services rendered in dealing directly with a union, in advising hospital management of its
2702 responsibilities under the National Labor Relations Act, or for services at an administrative
2703 agency or court or for services by an attorney in preparation for the agency or in court
2704 proceeding shall not be support or opposition to unionization.

2705 The executive office shall establish rates on a prospective basis, subject to rules and
2706 regulations promulgated by the executive office.

2707 In establishing rates for nursing pools under section 72Y of chapter 111, the executive
2708 office shall establish annually the limit for the rate for service provided by nursing pools to
2709 licensed facilities. The executive office shall establish industry-wide class rates for such services
2710 and shall establish separate class rates for services provided to nursing facilities and hospitals.
2711 The executive office shall establish separate rates for registered nurses, licensed practical nurses
2712 and certified nursing assistants. The executive office may establish rates by geographic region.
2713 The rates shall include an allowance for wages, payroll taxes and fringe benefits, which shall be
2714 based upon, and shall not exceed, median wages, payroll taxes and fringe benefits paid to
2715 permanent medical personnel of the same type at health care facilities in the same geographic
2716 region. The rates shall also include an allowance for reasonable administrative expenses and a
2717 reasonable profit factor, as determined by the executive office. The executive office may exempt
2718 from the rates certain categories, as defined by the executive office, of fixed-term employees that
2719 work exclusively at a particular health care facility for a period of at least 90 days and for whose

2720 services there is a contract between a facility and a nursing pool registered with the department
2721 of public health. The executive office shall establish procedures by which nursing pools shall
2722 submit cost reports, which may be subject to audit, to the executive office to establish rates. The
2723 executive office shall determine the nursing pool rate contained in this paragraph by considering
2724 wage and benefit data collected from cost reports received from nursing pools and from health
2725 care facilities and other relevant information gathered through other collection tools or
2726 reasonable methodologies.

2727 Except as otherwise provided in this section any person aggrieved by any rate
2728 determination made under this section shall have a right of appeal as provided under section 13E.

2729 The executive office may enter into such contracts or agreements with the federal
2730 government, a political subdivision of the commonwealth or any public or private corporation or
2731 organization, as it deems necessary; provided, however, that the executive office shall not enter
2732 into any contract or agreement with a private corporation or organization to furnish information
2733 and statistical data to be used by said executive office as its sole basis for setting rates, if such
2734 private corporation or organization is to make or receive payments based upon the rates so set.

2735 Each governmental unit shall cooperate with the executive office at all times in the
2736 furtherance of the executive office's purposes. Each state institution shall permit the executive
2737 office or any designated representatives of the executive office, to examine its books and
2738 accounts and shall file with the executive office from time to time or upon request such data,
2739 statistics, schedules or other information as the executive office may reasonably require.

2740 Each rate established by the executive office shall be a regulation and shall be subject to
2741 review as hereinafter provided. The executive office shall promulgate rules and regulations for

2742 the administration of its duties and the determination of rates as are herein required subject to the
2743 procedures prescribed by chapter 30A. Every rate, classification and other regulation established
2744 by the executive office shall be consistent where applicable with the principles of reimbursement
2745 for provider costs in effect from time to time under Titles XVIII and XIX of the Social Security
2746 Act governing reimbursements or grants available to the commonwealth, its departments,
2747 agencies, boards, divisions or political subdivisions for general health supplies, care and
2748 rehabilitative services and accommodations.

2749 In the event that any aggregate rates certified by the executive office exceed the upper
2750 limit of payment in effect for any period under Titles XVIII or Title XIX of the Social Security
2751 Act or any other requirement of said Titles, where applicable, the executive office shall re-
2752 determine and recertify any such aggregate rates in order to bring them into compliance with
2753 such federal requirement for the entire period during which such upper limit is effective.

2754 This section shall not apply to acute or non-acute hospitals; provided, however, that this
2755 section shall apply to acute and non-acute hospitals for services under the workers'
2756 compensation act.

2757 Section 13E. Except for rates established under section 13F, any person, corporation or
2758 other party aggrieved by an interim rate or a final rate established by the executive office or a
2759 governmental unit designated to perform ratemaking functions by the executive office, or by
2760 failure of the executive office to set a rate or to take other action required by law and desiring a
2761 review thereof shall, within 30 days after said rate is filed with the state secretary or may, at any
2762 time, if there is a failure to determine a rate or take any action required by law, file an appeal
2763 with the division of administrative law appeals established by section 4H of chapter 7. Any

2764 appeal filed under this section shall be accompanied by a certified statement that said appeal is
2765 not interposed for delay. On appeal, the rate determined for any provider of services shall be
2766 adequate, fair and reasonable for such provider, based upon, the costs of such provider, but not
2767 limited thereto.

2768 On an appeal from an interim rate or a final rate the division of administrative law
2769 appeals shall conduct an adjudicatory proceeding under chapter 30A, and said division shall file
2770 its decision with the secretary of the executive office and the state secretary within 30 days after
2771 the conclusion of the hearing.

2772 Said decision shall contain a statement of the reasons for such decision, including a
2773 determination of each issue of fact or law upon which such decision was based. If such decision
2774 results in a recommendation for a rate different from that certified, the executive office shall
2775 establish a new rate based upon such statement of reasons. If the secretary of the executive office
2776 determines that the statement of reasons is inadequate to determine a fair, reasonable and
2777 adequate rate, it may remand the appeal to the hearing officer for further investigation. Any party
2778 aggrieved by a decision of the division may, within 30 days of the receipt of such decision, file a
2779 petition for review in superior court for the county of Suffolk, which shall have exclusive
2780 jurisdiction of such review.

2781 A provider may appeal as an aggrieved party under the preceding sentence, in the event
2782 that a remand by the executive office to a hearing officer does not result in a final decision by the
2783 executive office within 21 days of the date of remand.

2784 The petition shall set forth the grounds upon which the decision of the division should be
2785 set aside. The aggrieved party shall, within 7 days after the petition for review is filed, notify the

2786 executive office and all the parties to the appeal before said division that a petition for review has
2787 been filed by sending each a copy thereof. Within 40 days after the petition for review is filed, or
2788 within such further time as the court may allow, the division of administrative law appeals shall
2789 file in court the original or a certified copy of the record under review. The court may affirm,
2790 modify or set aside the decision of the executive office in whole or in part, remand the decision
2791 to the executive office for further proceedings or enter such other order as justice may require.
2792 Nothing in this section shall be construed to prevent the division from granting temporary relief
2793 if, in its discretion, such relief is justified nor, from informally adjusting or settling controversies
2794 with the consent of all parties.

2795 Judicial review shall be governed by section 14 of chapter 30A to the extent not
2796 inconsistent with this section.

2797 Section 13E ½. All purchasers and third party payers, excluding purchasers and payers
2798 under the workers' compensation act, except as provided in chapter 152, may enter into
2799 contractual arrangements with acute and non-acute hospitals for services. No such arrangement,
2800 including but not limited to, prices or charges which may be charged for non-contracted services
2801 or which may be negotiated in individual contracts between such purchasers or third party payers
2802 and such acute or non-acute hospitals, shall be subject to prior approval by any public agency;
2803 provided, however, that nothing in this chapter shall limit the authority of the executive office to
2804 establish rates of payment for all health care services adjudged compensable under chapter 152,
2805 and provided, further, that charges established by an acute or non-acute hospital for health care
2806 services rendered shall be uniform for all patients receiving comparable services.

2807 Any acute or non-acute hospital that makes a charge or accepts payment based upon a
2808 charge in excess of that filed, required or approved by the executive office or that fails to file any
2809 data, statistics or schedules or other information required under this chapter or by any regulation
2810 promulgated by the executive office or which falsifies the same, shall be subject to a civil
2811 penalty of not more than \$1,000 for each day on which such violation occurs or continues, which
2812 penalty may be assessed in an action brought on behalf of the commonwealth in any court of
2813 competent jurisdiction. The attorney general shall bring any appropriate action, including
2814 injunctive relief, as may be necessary for the enforcement of this chapter.

2815 Section 13F. All rates of payment to acute hospitals and non-acute hospitals under Title
2816 XIX shall be established by contract between the provider of such hospital services and the
2817 office of Medicaid, except as provided in subsections (a) and (b), or otherwise permitted by law.
2818 All rates shall be subject to all applicable Title XIX statutory and regulatory requirements and
2819 shall include reimbursement for the reasonable cost of providing competent interpreter services
2820 under section 25J of chapter 111 or section 23A of chapter 123.

2821 All such rates for non-acute hospitals shall be effective as of the date specified in section
2822 13A, unless otherwise specified by law.

2823 (a) For disproportionate share hospitals, the executive office shall establish rates that
2824 equal the financial requirements of providing care to recipients of medical assistance.

2825 (b) The executive office, or governmental unit designated by the executive office, shall
2826 establish rates of payment which shall apply to emergency services and continuing emergency
2827 care provided in acute hospitals to medical assistance program recipients, including examination
2828 or treatment for an emergency medical condition or active labor in women or any other care

2829 rendered to the extent required by 42 USC 1395(dd), unless such services are provided under an
2830 agreement between the office of Medicaid and the acute hospital. Such rates of payment shall
2831 reflect the reasonable costs of providing such care, including the costs of providing competent
2832 interpreter services under section 25J of chapter 111 or section 23A of chapter 123 and shall take
2833 into account the characteristics of the hospital in which such care is provided, including, but not
2834 limited to, its status as a teaching hospital, specialty hospital, disproportionate share hospital,
2835 pediatric hospital, pediatric specialty unit or sole community provider. An acute hospital shall,
2836 when a medical assistance program recipient requires post emergency room care and, after
2837 screening and stabilizing the patient's condition, notify the office of Medicaid or its designated
2838 representative and assist said office, to the extent possible, in transferring the recipient to an
2839 appropriate medical setting under said office's direction. Nothing in this section shall be
2840 construed to require the hospital to breach its obligation under said 42 USC 1395(dd) or require
2841 the recipient to forego any right to refuse transfer under said 42 USC 1395(dd). If an acute
2842 hospital is unable or prohibited by law or regulation from transferring the patient under said
2843 office's direction, said executive office shall pay for any and all care associated with such
2844 patient's treatment including, but not limited to, care or services provided in the emergency room
2845 or in an inpatient or outpatient setting. Whenever said office is required to pay for such care
2846 rendered in a non-emergency room setting, said office shall pay all reasonable costs for such
2847 services in such hospital, as determined by the executive office under this chapter and consistent
2848 with Title XIX laws.

2849 No acute hospital may charge to a governmental unit for services provided to publicly
2850 aided patients at a rate higher than the rate payable by the office of Medicaid under Title XIX for

2851 the same service, unless such service is provided by said office under a unique arrangement such
2852 as a selective contract or a managed care contract.

2853 Nothing in this chapter shall be construed to conflict with a waiver of otherwise
2854 applicable federal requirements which the office of Medicaid may obtain from the secretary of
2855 health and human services to implement a primary care case management system for delivering
2856 services, or to implement any other type of managed care service delivery system in which the
2857 eligible recipient is directed to obtain services exclusively from 1 provider or 1 group of
2858 providers.

2859 If the office of Medicaid contracts with any third party payer for the provision of medical
2860 benefits for medical assistance recipients under Title XIX, said office shall assure that on a
2861 quarterly basis such contracted third party payers notify each acute hospital of the number of
2862 inpatient days of service provided by the hospital to such recipients covered by such contracts.

2863 (c) The executive office, or a governmental unit designated to perform ratemaking
2864 functions by the executive office, shall establish rates of payment which shall apply to
2865 community hospitals located in rural and isolated areas where access to other such providers is
2866 not reasonably available. Such hospitals, specially designated by the commonwealth as sole
2867 community providers, shall receive payment rates calculated to reflect the rural characteristics of
2868 such community hospital and the essential nature of the services they provide, which rates shall
2869 not be less than 97 per cent of such hospitals' reasonable financial requirements.

2870 Section 13G. The executive office, or a governmental unit designated to perform
2871 ratemaking functions by the executive office, shall not consider the following as resources of
2872 such hospitals in the establishment, review or approval of acute and non-acute hospital rates and

2873 charges: restricted and unrestricted grants; gifts; contributions; bequests; fund principle; term
2874 endowments and endowment balances; restricted gifts; unrestricted gifts and all income from any
2875 of the foregoing, including unrestricted income from endowment funds and income and gains
2876 from investment of unrestricted funds. The following words shall have the following meanings
2877 as used in this paragraph:

2878 “Income and gains from investment of unrestricted funds”, interest, dividends, rents or
2879 other income on investments, including net gains or losses resulting from investment
2880 transactions.

2881 “Term endowment”, funds available upon termination of restrictions.

2882 “Unrestricted gifts”, gifts, grants, contributions and bequests, upon which there are no
2883 restrictions imposed by the donor.

2884 “Unrestricted income from endowment funds”, income earned on investment of
2885 endowment funds which have no restrictions on income.

2886 An acute or non-acute care hospital aggrieved by any action or failure to act by the
2887 executive office under this chapter may file an appeal under section 13E.

2888 Section 13H. No acute hospital shall deny access to care and services which the hospital
2889 would provide under this chapter to recipients of benefits under chapter 117A.

2890 Section 13I. Notwithstanding any provisions of this chapter to the contrary, all costs and
2891 charges for patients who are residents of other countries shall, as provided herein, be exempted
2892 from the limitations imposed by this chapter. Any hospital shall be allowed to impose a
2893 surcharge on the normal charges that would otherwise be allowed for such residents of other

2894 countries. Such surcharges shall not be included in the calculation of gross patient service
2895 revenues. The normal charge and the patient discharge statistics shall otherwise be included
2896 under this chapter.

2897 Section 13J. A health maintenance organization organized under chapter 176G may (i)
2898 negotiate directly with any hospital with respect to such health maintenance organization's rate
2899 of payment for hospital services and (ii) enter into an agreement with such hospital reflecting
2900 such rate of payment without the approval of the executive office. The specification in this
2901 section of contracting rights of health maintenance organizations shall not be construed as
2902 affirming or denying such rights with respect to any other third party payer.

2903 Section 13K. Upon petition of a receiver appointed under section 72 N of chapter 111,
2904 the executive office shall, under regulations to be promulgated hereunder, adjust the facility's
2905 rate, if necessary, to insure compensation of the receiver and payment for a bond. Such
2906 adjustment shall not be in effect if the licensee is under the jurisdiction of the United States
2907 Bankruptcy Court.

2908 SECTION 98. Section 14 of said chapter 118E, as appearing in the 2010 Official Edition,
2909 is hereby amended by striking out, in lines 4 and 5 and 66, the words "division of health care
2910 finance and policy" and inserting in place thereof, in each instance, the following words:-
2911 executive office of health and human services or a governmental unit designated by the executive
2912 office.

2913 SECTION 99. Subsection (e) of section 22 of said chapter 118E, as so appearing, is
2914 hereby amended by striking out, in lines 46 and 47, the words "36 of chapter 118G" and
2915 inserting in place thereof the following figure:- 69.

2916 SECTION 100. Subsection (k) of said section 22 of said chapter 118E, as so appearing, is
2917 hereby amended by striking out, in lines 93 and 96, the word “118G” and inserting in place
2918 thereof, in each instance, the following word:- 118E.

2919 SECTION 101. Said section 22 of said chapter 118E, as so appearing, is hereby amended
2920 by striking out, in lines 44 and 45, 65, 71, 86 and 87 and 110, the words “division of health care
2921 finance and policy” and inserting in place thereof, in each instance, the following words:-
2922 executive office of health and human services.

2923 SECTION 102. Subsection (m) of said section 22 of said chapter 118E, as so appearing,
2924 is hereby amended by striking out, in lines 112 and 113, the words “39 of chapter 118G” and
2925 inserting in place thereof the following figure:- 69.

2926 SECTION 103. Section 23 of said chapter 118E, as so appearing, is hereby amended by
2927 striking out, in line 74, the words “39 of chapter 118G” and inserting in place thereof the
2928 following figure:- 69.

2929 SECTION 104. Said chapter 118E is hereby further amended by inserting after section 62
2930 the following 13 sections:-

2931 Section 63. (a) For the purposes of this section, the following words shall have the
2932 following meanings:—

2933 “Assessment”, the user fee imposed under this section; provided that for all nursing
2934 homes, the user fee shall be imposed per non Medicare reimbursed patient day; provided, further
2935 that a Medicare-reimbursed patient day shall be a Medicare Part A patient day paid for under

2936 either an indemnity fee-for-service arrangement or a Medicare health maintenance organization
2937 contract.

2938 “Nursing home”, a nursing home or a distinct part of a nursing unit of a hospital or other
2939 facility licensed by the department of public health under section 71 of chapter 111.

2940 “Patient day”, a day of care provided to an individual patient by a nursing home.

2941 (b) Each nursing home shall pay an assessment per non-Medicare reimbursed patient day.

2942 The assessment shall be sufficient in the aggregate to generate \$145 million in each fiscal year.

2943 The assessment shall be implemented as a broad based health care-related fee as defined in 42

2944 U.S.C. § 1396b(w)(3)(B). The assessment shall be paid to the executive office quarterly. The

2945 executive office may promulgate regulations that authorize the assessment of interest on any

2946 unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees at a

2947 rate not to exceed 5 per cent per month. The receipts from the assessment, any federal financial

2948 participation received by the commonwealth as a result of expenditures funded by these

2949 assessments and interest thereon shall be credited to the General Fund.

2950 (c) The secretary of the executive office shall prepare a form on which each nursing

2951 home shall report quarterly its total patient days and shall calculate the assessment due. The

2952 secretary of the executive office shall distribute the forms to each nursing home at least annually.

2953 The failure to distribute the form or the failure to receive a copy of the form shall not stay the

2954 obligation to pay the assessment by the date specified in this section. The executive office may

2955 require additional reports, including but not limited to monthly census data, as it considers

2956 necessary to monitor collections and compliance.

2957 (d) The executive office shall have the authority to inspect and copy the records of a
2958 nursing home to audit its calculation of the assessment. In the event that the executive office
2959 determines that a nursing home has either overpaid or underpaid the assessment, the executive
2960 office shall notify the nursing home of the amount due or refund the overpayment. The executive
2961 office may impose per diem penalties if a nursing home fails to produce documentation as
2962 requested by the executive office.

2963 (e) In the event that a nursing home is aggrieved by a decision of the executive office as
2964 to the amount due, the nursing home may file an appeal to the division of administrative law
2965 appeals within 60 days of the date of the notice of underpayment or the date the notice was
2966 received, whichever is later. The division of administrative law appeals shall conduct each
2967 appeal as an adjudicatory proceeding under chapter 30A and a nursing home aggrieved by a
2968 decision of the division of administrative law appeals shall be entitled to judicial review under
2969 section 14 of said chapter 30A.

2970 (f) The secretary of the executive office may enforce this section by notifying the
2971 department of public health of unpaid assessments. Within 45 days after notice to a nursing home
2972 of amounts due, the department shall revoke licensure of a nursing home that fails to remit
2973 delinquent fees.

2974 (g) The executive office, in consultation with the office of Medicaid, shall promulgate
2975 regulations necessary to implement this section.

2976 Section 64. As used in sections 64 to 69, inclusive, the following words shall, unless the
2977 context clearly requires otherwise, have the following meanings:-

2978 "Acute hospital", the teaching hospital of the University of Massachusetts medical school
2979 and any hospital licensed under section 51 of chapter 111 and which contains a majority of
2980 medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public
2981 health.

2982 "Allowable reimbursement", payment to acute hospitals and community health centers
2983 for health services provided to uninsured or underinsured patients of the commonwealth under
2984 section 69 and any further regulations promulgated by the health safety net office.

2985 "Ambulatory surgical center", a distinct entity that operates exclusively to provide
2986 surgical services to patients not requiring hospitalization and meets the requirements of the
2987 federal Health Care Financing Administration for participation in the Medicare program.

2988 "Ambulatory surgical center services", services described for purposes of the Medicare
2989 program under 42 U.S.C. 1395k(a)(2)(F)(I); provided that "ambulatory surgical center services"
2990 shall include facility services only and shall not include surgical procedures.

2991 "Bad debt", an account receivable based on services furnished to a patient which: (i) is
2992 regarded as uncollectible, following reasonable collection efforts consistent with regulations of
2993 the office, which regulations shall allow third party payers to negotiate with hospitals to collect
2994 the bad debts of its enrollees; (ii) is charged as a credit loss; (iii) is not the obligation of a
2995 governmental unit or the federal government or any agency thereof; and (iv) is not a
2996 reimbursable health care service.

2997 "Community health center", a health center operating in conformance with the
2998 requirements of Section 330 of United States Public Law 95-626, including all community health
2999 centers which file cost reports as requested by the institute of health care finance and policy.

3000 "Director", the director of the health safety net office.

3001 "DRG", a patient classification scheme known as diagnosis related grouping, which
3002 provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost
3003 incurred by the hospital.

3004 "Emergency bad debt", bad debt resulting from emergency services provided by an acute
3005 hospital to an uninsured or underinsured patient or other individual who has an emergency
3006 medical condition that is regarded as uncollectible, following reasonable collection efforts
3007 consistent with regulations of the office.

3008 "Emergency medical condition", a medical condition, whether physical, behavioral,
3009 related to a substance use disorder or mental, manifesting itself by symptoms of sufficient
3010 severity, including severe pain, that the absence of prompt medical attention could reasonably be
3011 expected by a prudent layperson who possesses an average knowledge of health and medicine to
3012 result in placing the health of the person or another person in serious jeopardy, serious
3013 impairment to body function or serious dysfunction of any body organ or part or, with respect to
3014 a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42
3015 U.S.C. 1295dd(e)(1)(B).

3016 "Emergency services", medically necessary health care services provided to an individual
3017 with an emergency medical condition.

3018 "Financial requirements", a hospital's requirement for revenue which shall include, but
3019 not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of
3020 depreciation of plant and equipment and the reasonable costs associated with changes in medical
3021 practice and technology.

3022 "Fund", the Health Safety Net Trust Fund established under section 66.

3023 "Fund fiscal year", the 12-month period starting in October and ending in September.

3024 "Gross patient service revenue", the total dollar amount of a hospital's charges for
3025 services rendered in a fiscal year.

3026 "Health services", medically necessary inpatient and outpatient services as mandated
3027 under Title XIX of the federal Social Security Act; provided, that "health services" shall not
3028 include: (1) nonmedical services, such as social, educational and vocational services; (2)
3029 cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and
3030 consultations; (5) court testimony; (6) research or the provision of experimental or unproven
3031 procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-
3032 surgery hormone therapy; and (7) the provision of whole blood, but the administrative and
3033 processing costs associated with the provision of blood and its derivatives shall be payable.

3034 "Managed care organization", a managed care organization, as defined in 42 CFR 438.2,
3035 and any eligible health insurance plan, as defined in section 1 of chapter 118H, that contracts
3036 with MassHealth or the commonwealth health insurance connector authority; provided, however,
3037 that "managed care organization" shall not include a senior care organization, as defined in
3038 section 9D of chapter 118E.

3039 "Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge
3040 payors to acute hospitals for health services and ambulatory surgical centers for ambulatory
3041 surgical center services; provided, however, that "payments subject to surcharge" shall not
3042 include: (i) payments, settlements and judgments arising out of third party liability claims for
3043 bodily injury which are paid under the terms of property or casualty insurance policies; (ii)

3044 payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in
3045 policies issued under chapter 176K or similar policies issued on a group basis; provided further,
3046 that "payments subject to surcharge" shall include payments made by a managed care
3047 organization on behalf of: (i) Medicaid recipients under age 65; and (ii) enrollees in the
3048 commonwealth care health insurance program; and provided further, that "payments subject to
3049 surcharge" may exclude amounts established under regulations promulgated by the division for
3050 which the costs and efficiency of billing a surcharge payor or enforcing collection of the
3051 surcharge from a surcharge payor would not be cost effective.

3052 "Pediatric hospital", an acute care hospital which limits services primarily to children and
3053 which qualifies as exempt from the Medicare Prospective Payment system regulations.

3054 "Pediatric specialty unit", a pediatric unit of an acute care hospital in which the ratio of
3055 licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20; provided
3056 that in calculating that ratio, licensed pediatric beds shall include the total of all pediatric service
3057 beds, and the total of all licensed hospital beds shall include the total of all licensed acute care
3058 hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put
3059 forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

3060 "Private sector charges", gross patient service revenue attributable to all patients less
3061 gross patient service revenue attributable to Titles XVIII and XIX, other public-aided patients,
3062 reimbursable health services and bad debt.

3063 "Reimbursable health services", health services provided to uninsured and underinsured
3064 patients who are determined to be financially unable to pay for their care, in whole or part, under
3065 applicable regulations of the office; provided that the health services are services provided by

3066 acute hospitals or services provided by community health centers; and provided further, that such
3067 services shall not be eligible for reimbursement by any other public or private third-party payer.

3068 "Resident", a person living in the commonwealth, as defined by the office by regulation;
3069 provided, however, that such regulation shall not define as a resident a person who moved into
3070 the commonwealth for the sole purpose of securing health insurance under this chapter.

3071 Confinement of a person in a nursing home, hospital or other medical institution shall not in and
3072 of itself, suffice to qualify such person as a resident.

3073 "Surcharge payor", an individual or entity that pays for or arranges for the purchase of
3074 health care services provided by acute hospitals and ambulatory surgical center services provided
3075 by ambulatory surgical centers, as defined in this section; provided, however, that the term
3076 "surcharge payor" shall include a managed care organization; and provided further, that
3077 "surcharge payor" shall not include Title XVIII and Title XIX programs and their beneficiaries or
3078 recipients, other governmental programs of public assistance and their beneficiaries or recipients
3079 and the workers' compensation program established under chapter 152.

3080 "Underinsured patient", a patient whose health insurance plan or self-insurance health
3081 plan does not pay, in whole or in part, for health services that are eligible for reimbursement
3082 from the health safety net trust fund, provided that such patient meets income eligibility
3083 standards set by the office.

3084 "Uninsured patient", a patient who is a resident of the commonwealth, who is not covered
3085 by a health insurance plan or a self-insurance health plan and who is not eligible for a medical
3086 assistance program.

3087 Section 65. (a) There shall be established within the office of Medicaid a health safety net
3088 office which shall be under the supervision and control of a director. The director shall be
3089 appointed by the secretary of the executive office and shall be a person of skill and experience in
3090 the field of health care finance and administration. The director shall be the executive and
3091 administrative head of the office and shall be responsible for administering and enforcing the law
3092 relative to the office and to each administrative unit of the office. The director shall receive such
3093 salary as may be determined by law, and shall devote full time to the duties of the office. In the
3094 case of an absence or vacancy in the office of the director, or in the case of disability as
3095 determined by the secretary of the executive office, the secretary of the executive office may
3096 designate an acting director to serve as director until the vacancy is filled or the absence or
3097 disability ceases. The acting director shall have all the powers and duties of the director and shall
3098 have similar qualifications as the director.

3099 (b) The office shall have the following powers and duties: (1) to administer the Health
3100 Safety Net Trust Fund, established under section 66, and to require payments to the fund
3101 consistent with acute hospitals' and surcharge payors' liability to the fund, as determined under
3102 sections 67 and 68, and any further regulations promulgated by the office; (2) to set in
3103 consultation with the office of Medicaid, reimbursement rates for payments from the fund to
3104 acute hospitals and community health centers for reimbursable health services provided to
3105 uninsured and underinsured patients and to disburse monies from the fund consistent with such
3106 rates; provided that the office shall implement a fee-for-service reimbursement system for acute
3107 hospitals; (3) to promulgate regulations further defining: (a) eligibility criteria for reimbursable
3108 health services; (b) the scope of health services that are eligible for reimbursement by the Health
3109 Safety Net Trust Fund; (c) standards for medical hardship; and (d) standards for reasonable

3110 efforts to collect payments for the costs of emergency care; provided that the office shall verify
3111 eligibility using the eligibility system of the office of Medicaid and other appropriate sources to
3112 determine the eligibility of uninsured and underinsured patients for reimbursable health services
3113 and shall establish other procedures to ensure that payments from the fund are made for health
3114 services for which there is no other public or private third party payer, including disallowance of
3115 payments to acute hospitals and community health centers for health services provided to
3116 individuals if reimbursement is available from other public or private sources; (4) to develop
3117 programs and guidelines to encourage maximum enrollment of uninsured individuals who
3118 receive health services reimbursed by the fund into health care plans and programs of health
3119 insurance offered by public and private sources and to promote the delivery of care in the most
3120 appropriate setting, provided that the programs and guidelines are developed in consultation with
3121 the commonwealth health insurance connector, established under chapter 176Q; and provided
3122 further that these programs shall not deny payments from the fund because services should have
3123 been provided in a more appropriate setting if the hospital was required to provide the services
3124 under 42 U.S.C. 1395 (dd); (5) to conduct a utilization review program designed to monitor the
3125 appropriateness of services for which payments were made by the fund and to promote the
3126 delivery of care in the most appropriate setting; and to administer demonstration programs that
3127 reduce health safety net trust fund liability to acute hospitals, including a demonstration program
3128 to enable disease management for patients with chronic diseases, substance abuse and psychiatric
3129 disorders through enrollment of patients in community health centers and community mental
3130 health centers and through coordination between these centers and acute hospitals, provided, that
3131 the office shall report the results of these reviews annually to the joint committee on health care
3132 financing and the house and senate committees on ways and means; (6) to enter into agreements

3133 or transactions with any federal, state or municipal agency or other public institution or with a
3134 private individual, partnership, firm, corporation, association or other entity and to make
3135 contracts and execute all instruments necessary or convenient for the carrying on of its business;
3136 (7) to secure payment, without imposing undue hardship upon any individual, for unpaid bills
3137 owed to acute hospitals by individuals for health services that are ineligible for reimbursement
3138 from the Health Safety Net Trust Fund which have been accounted for as bad debt by the
3139 hospital and which are voluntarily referred by a hospital to the department for collection;
3140 provided, however that such unpaid charges shall be considered debts owed to the
3141 commonwealth and all payments received shall be credited to the fund; and provided, further,
3142 that all actions to secure such payments shall be conducted in compliance with a protocol
3143 previously submitted by the office to the joint committee on health care financing; (8) to require
3144 hospitals and community health centers to submit to the office data that it reasonably considers
3145 necessary; (9) to make, amend and repeal rules and regulations to effectuate the efficient use of
3146 monies from the Health Safety Net Trust Fund; provided, however, that the regulations shall be
3147 promulgated only after notice and hearing and only upon consultation with the board of the
3148 commonwealth health insurance connector, representatives of the Massachusetts Hospital
3149 Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts
3150 Safety Net Hospitals, the Conference of Boston Teaching Hospitals and the Massachusetts
3151 League of Community Health Centers; and (10) to provide an annual report at the close of each
3152 fund fiscal year to the joint committee on health care financing and the house and senate
3153 committees on ways and means, evaluating the processes used to determine eligibility for
3154 reimbursable health services, including the Virtual Gateway. The report shall include, but not be
3155 limited to, the following: (i) an analysis of the effectiveness of these processes in enforcing

3156 eligibility requirements for publicly-funded health programs and in enrolling uninsured residents
3157 into programs of health insurance offered by public and private sources; (ii) an assessment of the
3158 impact of these processes on the level of reimbursable health services by providers; and (iii)
3159 recommendations for ongoing improvements that will enhance the performance of eligibility
3160 determination systems and reduce hospital administrative costs.

3161 Section 66. (a) There shall be established and set up on the books of the commonwealth
3162 a fund to be known as the Health Safety Net Trust Fund, in this section and in sections 67 to 69,
3163 inclusive, called the fund, which shall be administered by the office. Expenditures from the fund
3164 shall not be subject to appropriation unless otherwise required by law. The purposes of the fund
3165 shall be: (i) to maintain a health care safety net by reimbursing hospitals and community health
3166 centers for a portion of the cost of reimbursable health services provided to low-income,
3167 uninsured or underinsured residents; and (ii) to support a portion of the costs of the Medicaid
3168 program this chapter and the commonwealth care health insurance program under chapter 118H.
3169 The office shall administer the fund using such methods, policies, procedures, standards and
3170 criteria that it deems necessary for the proper and efficient operation of the fund and programs
3171 funded by it in a manner designed to distribute the fund resources as equitably as possible. The
3172 director of the health safety net office shall determine annually the estimated expenses of the
3173 office to administer the fund.

3174 (b) The fund shall consist of all amounts paid by acute hospitals and surcharge payors
3175 under sections 67 and 68; all appropriations for the purpose of payments to acute hospitals or
3176 community health centers for health services provided to uninsured and underinsured residents;
3177 any transfers from the Commonwealth Care Trust Fund, established under section 2000 of
3178 chapter 29; and all property and securities acquired by and through the use of monies belonging

3179 to the fund and all interest thereon. Amounts placed in the fund shall, except for amounts
3180 transferred to the Commonwealth Care Trust Fund, be expended by the office for payments to
3181 hospitals and community health centers for reimbursable health services provided to uninsured
3182 and underinsured residents of the commonwealth, consistent with the requirements of this
3183 section and section 69 and the regulations promulgated by the office; provided, however, that
3184 expenses of the health safety net office under subsection (a) shall be expended annually from the
3185 fund; and provided further, that not more than \$6,000,000 shall be expended annually from the
3186 fund for demonstration projects that use case management and other methods to reduce the
3187 liability of the fund to acute hospitals; and provided further, that any amounts collected from
3188 surcharge payors in any year in excess of \$160,000,000, adjusted to reflect applicable surcharge
3189 credits, shall be transferred to the General Fund to support a portion of the costs of the Medicaid
3190 and commonwealth care health insurance programs. Any annual balance remaining in the fund
3191 after these payments have been made shall be transferred to the Commonwealth Care Trust
3192 Fund. All interest earned on the amounts in the fund shall be deposited or retained in the fund.
3193 The director shall from time to time requisition from the fund amounts that the director considers
3194 necessary to meet the current obligations of the office for the purposes of the fund and estimated
3195 obligations for a reasonable future period.

3196 Section 67. (a) An acute hospital's liability to the fund shall equal the product of (1) the
3197 ratio of its private sector charges to all acute hospitals' private sector charges; and (2)
3198 \$160,000,000. Annually, before October 1, the office shall establish each acute hospital's
3199 liability to the fund using the best data available, as determined by the health safety net office
3200 and shall update each acute hospital's liability to the fund as updated information becomes
3201 available. The office shall specify by regulation an appropriate mechanism for interim

3202 determination and payment of an acute hospital's liability to the fund. An acute hospital's
3203 liability to the fund shall in the case of a transfer of ownership be assumed by the successor in
3204 interest to the acute hospital.

3205 (b) The office shall establish by regulation an appropriate mechanism for enforcing an
3206 acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled
3207 payment to the fund. These enforcement mechanisms may include (1) an offset by the office of
3208 Medicaid of payments on the Title XIX claims of any such acute hospital or any health care
3209 provider under common ownership with the acute care hospital or any successor in interest to the
3210 acute hospital, and (2) the withholding by the office of Medicaid of the amount of payment owed
3211 to the fund, including any interest and late fees and the transfer of the withheld funds into the
3212 fund. If the office of Medicaid offsets claims payments as ordered by the office, it shall not be
3213 considered to be in breach of contract or any other obligation for the payment of non-contracted
3214 services and providers whose payment is offset under an order of the division shall serve all Title
3215 XIX recipients under the contract then in effect with the office of Medicaid, or, in the case of a
3216 non-contracting or disproportionate share hospital, under its obligation for providing services to
3217 Title XIX recipients under this chapter. In no event shall the office direct the office of Medicaid
3218 to offset claims unless an acute hospital has maintained an outstanding obligation to the fund for
3219 a period longer than 45 days and has received proper notice that the office of Medicaid intends to
3220 initiate enforcement actions under regulations promulgated by the office.

3221 Section 68. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge
3222 on all payments subject to surcharge as defined in section 64. The surcharge shall be distinct
3223 from any other amount paid by a surcharge payor for the services of an acute hospital or
3224 ambulatory surgical center. The surcharge amount shall equal the product of (i) the surcharge

3225 percentage and (ii) amounts paid for these services by a surcharge payor. The office shall
3226 calculate the surcharge percentage by dividing \$160,000,000 by the projected annual aggregate
3227 payments subject to the surcharge, excluding projected annual aggregate payments based on
3228 payments made by managed care organizations. The office shall determine the surcharge
3229 percentage before the start of each fund fiscal year and may re-determine the surcharge
3230 percentage before April 1 of each fund fiscal year if the office projects that the initial surcharge
3231 percentage established the previous October will produce less than \$150,000,000 or more than
3232 \$170,000,000 in surcharge payments, excluding payments made by managed care organizations.
3233 Before each succeeding October 1, the office shall re-determine the surcharge percentage
3234 incorporating any adjustments from earlier years. In each determination or redetermination of the
3235 surcharge percentage, the office shall use the best data available as determined by the office of
3236 Medicaid and may consider the effect on projected surcharge payments of any modified or
3237 waived enforcement under subsection (e). The office shall incorporate all adjustments, including,
3238 but not limited to, updates or corrections or final settlement amounts, by prospective adjustment
3239 rather than by retrospective payments or assessments.

3240 (b) Each acute hospital and ambulatory surgical center shall bill a surcharge payor an
3241 amount equal to the surcharge described in subsection (a) as a separate and identifiable amount
3242 distinct from any amount paid by a surcharge payor for acute hospital or ambulatory surgical
3243 center services. Each surcharge payor shall pay the surcharge amount to the office for deposit in
3244 the Health Safety Net Trust Fund on behalf of said acute hospital or ambulatory surgical center.
3245 Upon the written request of a surcharge payor, the office may implement another billing or
3246 collection method for the surcharge payor; provided, however, that the office has received all
3247 information that it requests which is necessary to implement such billing or collection method;

3248 and provided further, that the office shall specify by regulation the criteria for reviewing and
3249 approving such requests and the elements of such alternative method or methods.

3250 (c) The office shall specify by regulation appropriate mechanisms that provide for
3251 determination and payment of a surcharge payor's liability, including requirements for data to be
3252 submitted by surcharge payors, acute hospitals and ambulatory surgical centers.

3253 (d) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
3254 assumed by the successor in interest to the surcharge payor.

3255 (e) The office shall establish by regulation an appropriate mechanism for enforcing a
3256 surcharge payor's liability to the fund if a surcharge payor does not make a scheduled payment to
3257 the fund; provided, however, that the office may, for the purpose of administrative simplicity,
3258 establish threshold liability amounts below which enforcement may be modified or waived. Such
3259 enforcement mechanism may include assessment of interest on the unpaid liability at a rate not to
3260 exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5
3261 per cent per month. Such enforcement mechanism may also include notification to the office of
3262 Medicaid requiring an offset of payments on the claims of the surcharge payor, any entity under
3263 common ownership or any successor in interest to the surcharge payor, from the office of
3264 Medicaid in the amount of payment owed to the fund including any interest and penalties, and to
3265 transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as
3266 ordered by the office, the office of Medicaid shall be considered not to be in breach of contract
3267 or any other obligation for payment of non-contracted services, and a surcharge payor whose
3268 payment is offset under an order of the office shall serve all Title XIX recipients under the
3269 contract then in effect with the executive office of health and human services. In no event shall

3270 the office direct the office of Medicaid to offset claims unless the surcharge payor has
3271 maintained an outstanding liability to the fund for a period longer than 45 days and has received
3272 proper notice that the office intends to initiate enforcement actions under regulations
3273 promulgated by the office.

3274 (f) If a surcharge payor fails to file any data, statistics or schedules or other information
3275 required under this chapter or by any regulation promulgated by the office, the office shall
3276 provide written notice to the payor. If a surcharge payor fails to provide required information
3277 within 14 days after the receipt of written notice, or falsifies the same, the surcharge payor shall
3278 be subject to a civil penalty of not more than \$5,000 for each day on which the violation occurs
3279 or continues, which penalty may be assessed in an action brought on behalf of the
3280 commonwealth in any court of competent jurisdiction. The attorney general shall bring any
3281 appropriate action, including injunctive relief, necessary for the enforcement of this chapter.

3282 Section 69. (a) Reimbursements from the fund to hospitals and community health centers
3283 for health services provided to uninsured and underinsured individuals shall be subject to further
3284 rules and regulations promulgated by the office and shall be made in the following manner:-

3285 (1) Reimbursements made to acute hospitals shall be based on actual claims for
3286 health services provided to uninsured and underinsured patients that are submitted to the office,
3287 and shall be made only after determination that the claim is eligible for reimbursement under this
3288 chapter and any additional regulations promulgated by the office. Reimbursements for health
3289 services provided to residents of other states and foreign countries shall be prohibited and the
3290 office shall make payments to acute hospitals using fee-for-service rates calculated as provided
3291 in paragraphs (5) and (6).

3292 (2) The office shall, in consultation with the office of Medicaid, develop and
3293 implement procedures to verify the eligibility of individuals for whom health services are billed
3294 to the fund and to ensure that other coverage options are used fully before services are billed to
3295 the fund, including procedures adopted under section 66. The office may recover from a third
3296 party that is financially responsible for the costs attributable to services provided to an individual
3297 that were paid by the fund. A payment from the fund for such services shall be recoverable from
3298 the third party and the payment shall, after notice to the third party, operate as a lien under
3299 section 22 . The office shall review all claims billed to the fund to determine whether the patient
3300 is eligible for medical assistance under this chapter and whether any third party is financially
3301 responsible for the costs of care provided to the patient. In making these determinations, the
3302 office shall verify the insurance status of each individual for whom a claim is made using all
3303 sources of data available to the office. The office shall refuse to allow payments or shall disallow
3304 payments to acute hospitals and community health centers for free care provided to individuals if
3305 reimbursement is available from other public or private sources; provided, that payments shall
3306 not be denied from the fund because services should have been provided in a more appropriate
3307 setting if the hospital was required to provide these services under 42 U.S.C. 1395(dd).

3308 (3) The office shall require acute hospitals and community health centers to
3309 screen each applicant for reimbursed care for other sources of coverage and for potential
3310 eligibility for government programs and to document the results of that screening. If an acute
3311 hospital or community health center determines that an applicant is potentially eligible for
3312 Medicaid or for the commonwealth care health insurance program, established under chapter
3313 118H, or another assistance program, the acute hospital or community health center shall assist
3314 the applicant in applying for benefits under that program. The office shall audit the accounts of

3315 acute hospitals and community health centers to determine compliance with this section and shall
3316 deny payments from the fund for any acute hospital or community health center that fails to
3317 document compliance with this section.

3318 (4) Notwithstanding any general or special law to the contrary, an applicant for
3319 health safety net assistance shall, if eligible, be enrolled in MassHealth under section 9A or in the
3320 insurance reimbursement program, as provided in section 9C. An applicant deemed ineligible
3321 for either program and who is unable to make all or part of the payment for health services shall
3322 provide the name and address of the applicant's employer, if any, and the applicant's name,
3323 address, social security number and date of birth. The director of labor, in collaboration with the
3324 office, shall collaborate with the division of insurance and the department of revenue to
3325 implement this section and section 17 of chapter 176Q.

3326 (5) To pay community health centers for health services provided to uninsured
3327 individuals under this section, the office shall pay community health centers a base rate that shall
3328 be no less than the then-current Medicare Federally Qualified Health Center rate as required
3329 under 42 U.S.C. 13951 (a)(3), and the office shall add payments for additional services not
3330 included in the base rate, including, but not limited to, EPSDT services, 340B pharmacy, urgent
3331 care, and emergency room diversion services.

3332 (6) Reimbursements to acute hospitals and community health centers for bad debt
3333 shall be made upon submission of evidence, in a form to be determined by the office, that
3334 reasonable efforts to collect the debt have been made.

3335 (7) The office shall reimburse acute hospitals for health services provided to
3336 individuals based on the payment systems in effect for acute hospitals used by the United States

3337 Department of Health and Human Services Centers for Medicare & Medicaid Services to
3338 administer the Medicare Program under Title XVIII of the Social Security Act, including all of
3339 Medicare's adjustments for direct and indirect graduate medical education, disproportionate
3340 share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of
3341 the annual increase in the Medicare hospital market basket index. The office shall, in
3342 consultation with the office of Medicaid and the Massachusetts Hospital Association, promulgate
3343 regulations necessary to modify these payment systems to account for: (i) the differences
3344 between the program administered by the office and the Title XVIII Medicare program,
3345 including the services and benefits covered; (ii) grouper and DRG relative weights for purposes
3346 of calculating the payment rates to reimburse acute hospitals at rates no less than the rates they
3347 are reimbursed by Medicare; (iii) the extent and duration of covered services; (iv) the
3348 populations served; and (v) any other adjustments to the payment methodology under this section
3349 as considered necessary by the office, based upon circumstances of individual hospitals.

3350 Following implementation of this section, the office shall ensure that the allowable
3351 reimbursement rates under this section for health services provided to uninsured individuals shall
3352 not thereafter be less than rates of payment for comparable services under the Medicare program,
3353 taking into account the adjustments required by this section.

3354 (b) By April 1 of the year preceding the start of the fund fiscal year, the office
3355 shall, after consultation with the office of Medicaid, and using the best data available, provide an
3356 estimate of the projected total reimbursable health services provided by acute hospitals and
3357 community health centers and emergency bad debt costs, the total funding available and any
3358 projected shortfall after adjusting for reimbursement payments to community health centers. If a
3359 shortfall in revenue exists in any fund fiscal year to cover projected costs for reimbursement of

3360 health services, the office shall allocate that shortfall in a manner that reflects each hospital's
3361 proportional financial requirement for reimbursements from the fund, including, but not limited
3362 to, the establishment of a graduated reimbursement system and under any additional regulations
3363 promulgated by the office.

3364 (c) The executive office of health and human services shall enter into interagency
3365 agreements with the department of revenue to verify income data for patients whose health care
3366 services are reimbursed by the Health Safety Net Trust Fund and to recover payments made by
3367 the fund for services provided to individuals who are ineligible to receive reimbursable health
3368 services or on whose behalf the fund has paid for emergency bad debt. The office shall
3369 promulgate regulations requiring acute hospitals to submit data that will enable the department of
3370 revenue to pursue recoveries from individuals who are ineligible for reimbursable health services
3371 and on whose behalf the fund has made payments to acute hospitals for such services or
3372 emergency bad debt. Any amounts recovered, including amounts received under chapter 62D,
3373 shall be deposited in the Health Safety Net Trust Fund, established in section 66.

3374 (d) The office shall not at any time make payments from the fund for any period in excess
3375 of amounts that have been paid into or are available in the fund for that period, but the office
3376 may temporarily prorate payments from the fund for cash flow purposes.

3377 Section 70. (a) Acute hospitals and ambulatory surgical centers shall assess a health
3378 system benefit surcharge on all payments subject to surcharge in addition to the surcharge
3379 assessed under section 68. The health system benefit surcharge shall be distinct from any other
3380 amount paid by a surcharge payor for the services of an acute hospital or ambulatory surgical
3381 center. The health system benefit surcharge amount shall equal the product of (i) the health

3382 system benefit surcharge percentage and (ii) amounts paid for these services by a surcharge
3383 payor. The office shall calculate the health system benefit surcharge percentage by dividing
3384 \$40,000,000 by the projected annual aggregate payments subject to the health system benefit
3385 surcharge, excluding projected annual aggregate payments based on payments made by managed
3386 care organizations. The office shall determine the health system benefit surcharge percentage
3387 before the start of each fund fiscal year and may re-determine the health system benefit
3388 surcharge percentage before April 1 of each fund fiscal year if the office projects that the initial
3389 health system benefit surcharge percentage established the previous October will produce less
3390 than \$30,000,000 or more than \$50,000,000 in health system benefit surcharge payments,
3391 excluding payments made by managed care organizations. Before each succeeding October 1,
3392 the office shall re-determine the health system benefit surcharge percentage incorporating any
3393 adjustments from earlier years. In each determination or redetermination of the health system
3394 benefit surcharge percentage, the office shall use the best data available as determined by the
3395 office of Medicaid and may consider the effect on projected health system benefit surcharge
3396 payments of any modified or waived enforcement under subsection (e). The office shall
3397 incorporate all adjustments, including, but not limited to, updates or corrections or final
3398 settlement amounts, by prospective adjustment rather than by retrospective payments or
3399 assessments.

3400 (b) One half of all health system benefit surcharge payments shall be deposited in the
3401 Prevention and Wellness Trust Fund, established in section 2G of chapter 111. One half of all
3402 health system benefit surcharge payments shall be deposited in the e-Health Institute Fund,
3403 established in section 6E of chapter 40J.

3404 (c) Each acute hospital and ambulatory surgical center shall bill a health system benefit
3405 surcharge payor an amount equal to the health system benefit surcharge described in subsection
3406 (a) as a separate and identifiable amount distinct from any amount paid by a surcharge payor for
3407 acute hospital or ambulatory surgical center services. Each health system benefit surcharge payor
3408 shall pay the health system benefit surcharge amount to the office for deposit in the Prevention
3409 and Wellness Trust Fund and the e-Health Institute Fund on behalf of said acute hospital or
3410 ambulatory surgical center. Upon the written request of a health system benefit surcharge payor,
3411 the office may implement another billing or collection method for the health system benefit
3412 surcharge payor; provided, however, that the office has received all information that it requests
3413 which is necessary to implement such billing or collection method; and provided further, that the
3414 office shall specify by regulation the criteria for reviewing and approving such requests and the
3415 elements of such alternative method or methods.

3416 (d) The office shall specify by regulation appropriate mechanisms that provide for
3417 determination and payment of a health system benefit surcharge payor's liability, including
3418 requirements for data to be submitted by health system benefit surcharge payors, acute hospitals
3419 and ambulatory surgical centers.

3420 (e) A health system benefit surcharge payor's liability to the fund shall in the case of a
3421 transfer of ownership be assumed by the successor in interest to the health system benefit
3422 surcharge payor.

3423 (f) The office shall establish by regulation an appropriate mechanism for enforcing a
3424 health system benefit surcharge payor's liability to the fund if a health system benefit surcharge
3425 payor does not make a scheduled payment to the funds; provided, however, that the office may,

3426 for the purpose of administrative simplicity, establish threshold liability amounts below which
3427 enforcement may be modified or waived. Such enforcement mechanism may include assessment
3428 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent
3429 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement
3430 mechanism may also include notification to the office of Medicaid requiring an offset of
3431 payments on the claims of the health system benefit surcharge payor, any entity under common
3432 ownership or any successor in interest to the health system benefit surcharge payor, from the
3433 office of Medicaid in the amount of payment owed to the fund including any interest and
3434 penalties and to transfer the withheld funds into said fund. If the office of Medicaid offsets
3435 claims payments as ordered by the office, the office of Medicaid shall be considered not to be in
3436 breach of contract or any other obligation for payment of non-contracted services and a health
3437 system benefit surcharge payor whose payment is offset under an order of the office shall serve
3438 all Title XIX recipients under the contract then in effect with the executive office of health and
3439 human services. In no event shall the office direct the office of Medicaid to offset claims unless
3440 the health system benefit surcharge payor has maintained an outstanding liability to the fund for
3441 longer than 45 days and has received proper notice that the office intends to initiate enforcement
3442 actions under regulations promulgated by the office.

3443 (g) If a health system benefit surcharge payor fails to file any data, statistics or schedules
3444 or other information required under this chapter or by any regulation promulgated by the office,
3445 the office shall provide written notice to the payor. If a health system benefit surcharge payor
3446 fails to provide required information within 14 days after the receipt of written notice, or falsifies
3447 the same, the payor shall be subject to a civil penalty of not more than \$5,000 for each day on
3448 which the violation occurs or continues, which penalty may be assessed in an action brought on

3449 behalf of the commonwealth in any court of competent jurisdiction. The attorney general shall
3450 bring any appropriate action, including injunctive relief, necessary for the enforcement of this
3451 chapter.

3452 Section 71. As used in sections 71 to 76 inclusive, the following words shall, unless the
3453 context requires otherwise, have the following meanings:—

3454 “Consumer,” a person to whom a personal care attendant provides personal care services.

3455 “PCA quality home care workforce council”, “workforce council” or “the council”, the
3456 Personal Care Attendant quality home care workforce council established under section 72.

3457 “Personal care attendant,” a person, including a personal aide, who has been selected by a
3458 consumer or the consumer’s surrogate to provide personal care services to persons with
3459 disabilities or seniors under the MassHealth personal care attendant program or any successor
3460 program.

3461 “Surrogate” means the consumer’s legal guardian or person identified in a written
3462 agreement with the consumer as responsible for hiring, directing and firing on behalf of the
3463 consumer.

3464 Section 72. (a) The PCA quality home care workforce council is established in the
3465 executive office of health and human services but shall not be subject to the control thereof to
3466 ensure the quality of long-term, in-home, personal care by recruiting, training and stabilizing the
3467 work force of personal care attendants.

3468 (b) The PCA quality home care workforce council shall consist of 9 members appointed
3469 under this section. At all times, a majority of the members of the council shall be consumers as

3470 defined in this chapter. In making appointments to the council, the governor shall appoint the
3471 secretary of the executive office of health and human services or a designee, who shall serve as
3472 chair, the secretary of labor and workforce development or a designee and 1 member from a slate
3473 of 3 consumers recommended by the governor's special advisory commission on disability
3474 policy. The auditor shall appoint 1 member from a slate of 3 consumers recommended by the
3475 developmental disabilities council, 1 member from a slate of 3 consumers recommended by the
3476 Massachusetts office on disability, and 1 member from a slate of 3 consumers recommended by
3477 the statewide independent living council. The attorney general shall appoint 1 member from a
3478 slate of 3 consumers or consumer surrogates recommended by the Massachusetts home care
3479 association, 1 member from a slate of 3 consumers or consumer surrogates recommended by the
3480 Massachusetts council on aging and 1 member chosen at the attorney general's discretion. The
3481 secretary of the executive office of health and human services or a designee and the secretary of
3482 labor and workforce development or a designee shall be permanent members during their term in
3483 office. Appointees to the council shall serve 3-year terms. If a vacancy occurs, the executive
3484 officer who made the original appointment shall appoint a new council member to serve the
3485 remainder of the unexpired term or, in the event that the vacancy occurs as the result of the
3486 completion of a term, to serve a full term, and such appointment shall become immediately
3487 effective upon the member taking the appropriate oath. If the departing council member was
3488 appointed under a recommendation made under this paragraph, the executive officer shall make
3489 the new appointment from a slate of 3 recommendations put forth by the entity that originally
3490 recommended the departing council member. Members of the council may serve for successive
3491 terms of office. A majority of the council shall constitute a quorum for the transaction of any
3492 business. Members of the council shall not receive compensation for their council service but

3493 members shall be reimbursed for their actual expenses necessarily incurred in the performance of
3494 their duties.

3495 Section 73. (a) The workforce council shall carry out the following duties:

3496 (1) Undertake recruiting efforts to identify and recruit prospective personal care
3497 attendants;

3498 (2) Provide training opportunities, either directly or through contract, for personal
3499 care attendants and consumers;

3500 (3) Provide assistance to consumers and consumer surrogates in finding personal
3501 care attendants by establishing a referral directory of personal care attendants; provided that
3502 before placing a personal care attendant on the referral directory, the workforce council shall
3503 determine that the personal care attendant has met the requirements established by the executive
3504 office in its applicable regulations and has not stated in writing a desire to be excluded from the
3505 directory;

3506 (4) Provide routine, emergency and respite referrals of personal care attendants to
3507 consumers and consumer surrogates who are authorized to receive long-term, in-home personal
3508 care services through a personal care attendant;

3509 (5) Give preference in the recruiting, training, referral and employment of
3510 personal care attendants to recipients of public assistance or other low-income persons who
3511 would qualify for public assistance in the absence of such employment; and

3512 (6) Cooperate with state and local agencies on health and aging and other federal,
3513 state and local agencies to provide the services described and set forth in this section. If, in the

3514 course of carrying out its duties, the PCA quality home care workforce council identifies
3515 concerns regarding the services being provided by a personal care attendant, the workforce
3516 council shall notify the relevant office.

3517 (b) In determining how best to carry out its duties, the PCA quality home care workforce
3518 council shall identify existing personal care attendant recruitment, training and referral resources
3519 made available to consumers or the consumer's surrogate by other state and local public, private
3520 and nonprofit agencies. The council may coordinate with the agencies to provide a local presence
3521 for the council and to provide consumers or the consumer's surrogate greater access to personal
3522 care attendant recruitment, training and referral resources in a cost-effective manner. Using
3523 requests for proposals or similar processes, the council may contract with the agencies to provide
3524 recruitment, training and referral. The council shall provide an opportunity for consumer
3525 participation in coordination efforts.

3526 (c) The commonwealth shall provide to the council a list of all personal care attendants
3527 who have been paid through the MassHealth personal care attendant program and shall update
3528 the list not less frequently than every 6 months to ensure that the council has a complete and
3529 accurate list at all times.

3530 Section 74. (a) Consumers or the consumer's surrogate shall retain the right to select,
3531 hire, schedule, train, direct, supervise and terminate any personal care attendant providing
3532 services to them. Consumers or the consumer's surrogate may elect to receive long-term, in-
3533 home personal care services from personal care attendants who are not referred to them by the
3534 council.

3535 (b) Personal care attendants shall be considered public employees, as defined by and
3536 solely for the purposes of, chapter 150E and section 17J of chapter 180. Said chapter 150E shall
3537 apply to personal care attendants except to the extent that chapter 150E is inconsistent with this
3538 section, in which case this section shall control. In addition, personal care attendants shall be
3539 treated as state employees solely for the purposes of sections 17A and 17G of chapter 180.
3540 Personal care attendants shall not be considered public employees or state employees for any
3541 purpose other than those set forth in this paragraph. The PCA quality home care workforce
3542 council shall be the employer, as defined by and solely for the purposes of said chapter 150E and
3543 said sections 17A, 17G and 17J of said chapter 180 and deductions under said sections 17A, 17G
3544 and 17J may be made by any entity authorized by the commonwealth to compensate personal
3545 care attendants through the MassHealth personal care attendant program. Personal care
3546 attendants shall not be eligible for benefits through the group insurance commission, the state
3547 board of retirement or the state employee workers' compensation program.

3548 (c) Personal care attendants who are employees of the council under this section shall not
3549 be considered, for that reason, public employees or employees of the council for any other
3550 purpose. Nothing in this chapter shall alter the obligations of the commonwealth or the consumer
3551 to provide their share of social security, federal and state unemployment taxes, Medicare and
3552 worker's compensation insurance under the Federal Insurance Contributions Act, federal and
3553 state unemployment law or the Massachusetts Workers' Compensation Act.

3554 (d) Consistent with section 9A of chapter 150E, no personal care attendant shall engage
3555 in a strike and no personal care attendant shall induce, encourage or condone any strike, work
3556 stoppage, slowdown or withholding of services by any personal care attendant.

3557 (e) The only bargaining unit appropriate for the purpose of collective bargaining shall be
3558 a statewide unit of all personal care attendants. The showing of interest required to request an
3559 election is 10 per cent of the bargaining unit. An intervener seeking to appear on the ballot must
3560 make the same showing of interest.

3561 (f) The council or its contractors, may not be held vicariously liable for the action or
3562 inaction of any personal care attendant, whether or not that personal care attendant was included
3563 on the council's referral directory or referred to a consumer or the consumer's surrogate.

3564 (g) The members of the council shall be immune from any liability resulting from
3565 implementation of sections 71 to 76, inclusive.

3566 Section 75. (a) The PCA quality home care workforce council may make and execute
3567 contracts and all other instruments necessary or convenient for the performance of its duties or
3568 exercise of its powers, including contracts with public and private agencies, organizations,
3569 corporations and individuals to pay them for services rendered or furnished.

3570 (b) The council may offer and provide recruitment, training and referral services to
3571 personal care attendants and consumers of long-term in-home personal care services other than
3572 statutorily defined personal care attendants and consumers, for a fee to be determined by the
3573 council.

3574 (c) The council may issue rules or regulations, as necessary, for the purpose and policies
3575 of sections 71 to 76, inclusive.

3576 (d) Subject to appropriation, the chairperson of the council with the council's approval
3577 may establish offices, employ and discharge employees, agents and contractors as necessary, and

3578 prescribe their duties and powers and fix their compensation, incur expenses, and create such
3579 liabilities as are reasonable and proper for the administration of sections 71 to 76, inclusive.

3580 (e) The council may solicit and accept for use any grant of money, services or property
3581 from the federal government, the state or any political subdivision or agency thereof, including
3582 federal matching funds under Title XIX of the Federal Social Security Act, and do all things
3583 necessary to cooperate with the federal government, the state, or any political subdivision or
3584 agency thereof, in making an application for any grant.

3585 (f) The council may coordinate its activities and cooperate with similar agencies in other
3586 states.

3587 (g) The council may establish technical advisory committees to assist the council.

3588 (h) The council may keep records and engage in research and the gathering of relevant
3589 statistics.

3590 (i) The council may acquire, hold or dispose of real or personal property, or any interest
3591 therein, and construct, lease or otherwise provide facilities for the activities conducted under
3592 sections 71 to 76, inclusive, but the workforce council may not exercise any power of eminent
3593 domain.

3594 (j) The council may delegate to the appropriate persons the power to execute contracts
3595 and other instruments on its behalf and delegate any of its powers and duties, if consistent with
3596 sections 71 to 76, inclusive.

3597 (k) The council may perform other acts necessary or convenient to execute the powers
3598 expressly granted to it.

3599 Section 76. (a) The council shall conduct a performance review every 2 years, submit a
3600 report of the review to the legislature and the governor and make the report available to the
3601 public upon submission to the governor and the legislature.

3602 (b) The performance review and report shall include an evaluation of the health, welfare
3603 and satisfaction with services provided of the consumers receiving long-term in-home personal
3604 care services from personal care attendants under sections 71 to 76, inclusive, including the
3605 degree to which all required services have been delivered, the degree to which consumers
3606 receiving services from personal care attendants have ultimately required additional or more
3607 intensive services, such as home health care, or have been placed in other residential settings or
3608 nursing homes, the promptness of response to consumer complaints and any other issue
3609 considered to be relevant.

3610 (c) The performance review report shall provide an explanation of the full cost of
3611 personal care services, including the administrative costs of the council, unemployment
3612 compensation, Social Security and Medicare payroll taxes paid and any oversight costs.

3613 (d) The performance review report shall make recommendations to the legislature and the
3614 governor for any amendments to sections 71 to 76, inclusive to further ensure the well-being of
3615 consumers, and the most efficient means of delivering required services.

3616 SECTION 105. Chapter 118G of the General Laws is hereby repealed.

3617 SECTION 106. Section 14 of chapter 122 of the General Laws, as appearing in the 2010
3618 Official Edition, is hereby amended by striking out, in lines 17 and 18, the words “division of
3619 health care finance and policy” and inserting in place thereof the following words:- executive
3620 office of health and human services or a governmental unit designated by the executive office.

3621 SECTION 107. Section 32 of chapter 123 of the General Laws, as so appearing, is hereby
3622 amended by striking out, in lines 4 and 5, the words “division of health care finance and policy”
3623 and inserting in place thereof the following words:- executive office of health and human
3624 services or a governmental unit designated by the executive office.

3625 SECTION 108. Section 33 of said chapter 123, as so appearing, is hereby amended by
3626 striking out, in lines 20 and 25, the words “division of health care finance and policy” and
3627 inserting in place thereof, in each instance, the following words:- executive office of health and
3628 human services or a governmental unit designated by the executive office.

3629 SECTION 109. Section 16 of chapter 123B of the General Laws, as so appearing, is
3630 hereby amended by striking out, in lines 4 and 5, the words “division of health care finance and
3631 policy” and inserting in place thereof the following words:- executive office of health and human
3632 services or a governmental unit designated by the executive office.

3633 SECTION 110. Chapter 149 of the General Laws is hereby amended by striking out
3634 section 6D ½, as so appearing, and inserting in place thereof the following section:-

3635 Section 6D ½. No employee shall be penalized by an employer as a result of such
3636 employee’s filing of an application to the Health Safety Net Trust Fund or otherwise providing
3637 notice to the executive office of health and human services or to a health care provider in regard
3638 to the need for health care services for that employee that results in the employer being required
3639 to reimburse the fund in whole or in part.

3640 SECTION 111. Subsection (a) of section 188 of said chapter 149, as so appearing, is
3641 hereby amended by striking out the definition of “commissioner” and inserting in place thereof

3642 the following definition:- “Connector”, the commonwealth health insurance connector
3643 established by chapter 176Q.

3644 SECTION 112. Said subsection (a) of said section 188 of said chapter 149, as so
3645 appearing, is hereby further amended by striking out the definition of “division”.

3646 SECTION 113. Subsection (c) of said section 188 of said chapter 149, as amended by
3647 section 134 of chapter 3 of the acts of 2011, is hereby further amended by striking out, in line 29,
3648 the words “commissioner of health care finance and policy”, , and inserting in place thereof the
3649 following word:- connector.

3650 SECTION 114. Said subsection (c) of said section 188 of said chapter 149, as so
3651 amended, is hereby further amended by striking out, in lines 42, 57, 60, 69 and 70 the word
3652 “division” and inserting in place thereof, in each instance, the following word:- connector.

3653 SECTION 114A. Said subsection (c) of said section 188 of said chapter 149, as so
3654 amended, is hereby further amended by adding the following clause:-

3655 (11) In calculating the fair share assessment, employees who have qualifying health
3656 insurance coverage from a spouse, parent, veteran’s plan, Medicare, Medicaid or a plan or plans
3657 due to a disability or retirement shall not be included in the numerator or denominator for
3658 purposes of determining whether an employer is a contributing employer, as defined in 114.5
3659 CMR 16.02.

3660 SECTION 115. Said section 188 of said chapter 149, as appearing in the 2010 Official
3661 Edition, is hereby amended by striking out, in lines 37 and 38, and in line 41, the words

3662 “uncompensated care pool, or any successor thereto” and inserting in place thereof, in each
3663 instance, the following words:- health safety net.

3664 SECTION 116. Section 1 of chapter 150E of the General Laws, as amended by section
3665 23 of chapter 93 of the acts of 2011, is hereby amended by striking out the words “28 of chapter
3666 118G” and inserting in place thereof the following words:- 70 of chapter 118E.

3667 SECTION 117. Said section 1 of said chapter 150E of the General Laws, as so amended,
3668 is hereby further amended by striking out the words “29 of chapter 118G” and inserting in place
3669 thereof the following words:- 71 of chapter 118E.

3670 SECTION 118. Subsection (c) of section 46 of chapter 151A of the General Laws, as
3671 appearing in the 2010 Official Edition, is hereby amended by striking out clause (7) and inserting
3672 in place thereof the following 2 clauses:-

3673 (7) to the commonwealth health insurance connector, information under an interagency
3674 agreement for the administration and enforcement of sections 17 and 18 of chapter 176Q and for
3675 the administration of the fair share employer contribution requirement under section 188 of
3676 chapter 149.

3677 (7 ½) to the executive office of health and human services, information under an
3678 interagency agreement for the administration and enforcement of paragraph (4) of subsection (a)
3679 of section 69 of chapter 118E.

3680 SECTION 119. Section 13 of chapter 152 of the General Laws, as so appearing, is hereby
3681 amended by striking out, in lines 3 and 4, the words “division of health care finance and policy
3682 under the provisions of chapter one hundred and eighteen G” and inserting in place thereof the

3683 following words:- executive office of health and human services under chapter 118E or a
3684 governmental unit designated by the executive office.

3685 SECTION 120. Said section 13 of said chapter 152, as so appearing, is hereby further
3686 amended by striking out, in lines 9, 10, 16 and 21, the word “division” and inserting in place
3687 thereof, in each instance, the following words:- executive office.

3688 SECTION 121. Said section 13 of said chapter 152, as so appearing, is hereby further
3689 amended by striking out, in lines 22 and 23, the words “one hundred and eighteen G” and
3690 inserting in place thereof the following word:- 118E.

3691 SECTION 122. Said section 13 of said chapter 152, as so appearing, is hereby further
3692 amended by striking out, in line 37, the words “one hundred and eighteen G” and inserting in
3693 place thereof the following word:- 118E.

3694 SECTION 122A. Chapter 175 of the General Laws is hereby amended by inserting after
3695 section 47AA, the following section:-

3696 Section 47BB. For the purposes of this section, “telemedicine” as it pertains to the
3697 delivery of health care services, shall mean the use of interactive audio, video or other electronic
3698 media for the purpose of diagnosis, consultation or treatment. “Telemedicine” shall not include
3699 the use of audio-only telephone, facsimile machine or e-mail.

3700 An insurer may limit coverage of telemedicine services to those health care providers in a
3701 telemedicine network approved by the insurer.

3702 A contract that provides coverage for services under this section may contain a provision
3703 for a deductible, copayment or coinsurance requirement for a health care service provided

3704 through telemedicine as long as the deductible, copayment or coinsurance does not exceed the
3705 deductible, copayment or coinsurance applicable to an in-person consultation.

3706 Coverage for health care services under this section shall be consistent with coverage for
3707 health care services provided through in-person consultation.

3708 SECTION 123. Section 5 of chapter 176A of the General Laws, as so appearing, is
3709 hereby amended by striking out, in lines 34 and 35, the words “division of health care finance
3710 and policy, in this section called the division” and inserting in place thereof the following
3711 words:- executive office of health and human services, in this section called the executive office,
3712 or a governmental unit designated by the executive office.

3713 SECTION 124. Section 17 of said chapter 176A, as so appearing, is hereby amended by
3714 striking out, in lines 4 and 10, the word “division” and inserting in place thereof, in each
3715 instance, the following word:- institute.

3716 SECTION 124A. Section 6 of chapter 176J of the General Laws is hereby amended by
3717 striking subsection (c), as most recently amended by section 31A of chapter 359 of the acts of
3718 2010, and inserting in place thereof the following subsection:-

3719 (c) Notwithstanding any general or special law to the contrary, the commissioner may
3720 require carriers offering small group health insurance plans, including carriers licensed under
3721 chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to
3722 small group rating factors at least 90 days before their proposed effective date. The
3723 commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate
3724 or unreasonable in relation to the benefits charged. The commissioner shall disapprove any
3725 change to small group rating factors that is discriminatory or not actuarially sound. The

3726 determination of the commissioner shall be supported by sound actuarial assumptions and
3727 methods, which shall be provided in writing to the carrier. Rate filing materials submitted for
3728 review by the division shall be deemed confidential and exempt from the definition of public
3729 records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt
3730 regulations to carry out this section.

3731 SECTION 125. Subsection (d) of section 6 of chapter 176J of the General Laws, as
3732 appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 61 to 64,
3733 inclusive the words “, with the exception of any carrier whose Risk Based Capital Ratio, on a
3734 combined entity basis, falls below 300% for the most recent four consecutive quarters. For such
3735 carriers the reported contribution to surplus may not exceed 2.5 per cent”, and inserting in place
3736 thereof the following words:-; provided, however, that for any carrier whose Risk Based Capital
3737 Ratio, on a combined entity basis, falls below 300 per cent for the most recent 4 consecutive
3738 quarters, the reported contribution to surplus may not exceed 2.5 per cent; provided further, that
3739 for any carrier whose Risk Based Capital Ratio, on a combined entity basis, is greater than 600
3740 per cent for the most recent 4 consecutive quarters, the reported contribution to surplus shall not
3741 exceed 0.5 per cent; and provided further, that for any carrier whose Risk Based Capital Ratio is
3742 greater than 700 per cent for the 4 most recent 4 consecutive quarters, the reported contribution
3743 to surplus shall not exceed 0 per cent.

3744 SECTION 126. The second sentence of the second paragraph of subsection (a) of section
3745 11 of chapter 176J of the General Laws, as so appearing, is hereby amended by striking out, in
3746 lines 70 and 74, the words “6 of chapter 118G” and inserting in place thereof, in each instance,
3747 the following words:- 10 of chapter 12C.

3748 SECTION 127. Section 12 of said chapter 176J, as so appearing, is hereby amended by
3749 striking out, in line 59, the word “division” and inserting in place thereof the following word:-
3750 institute.

3751 SECTION 128. Said section 12 of said chapter 176J, as so appearing, is hereby further
3752 amended by adding the following subsection:-

3753 (h) Any rates offered by a carrier to a certified group purchasing cooperative under this
3754 section shall be based on those group base premium rates that apply to individuals and small
3755 employer groups enrolling outside the group purchasing cooperative but may differ based on:

3756 (1) a benefit rate adjustment factor that would apply to the certified group
3757 purchasing cooperative product if its covered benefits are different than those that apply outside
3758 the certified group purchasing cooperative;

3759 (2) a cooperative adjustment factor that would reflect the relative difference in
3760 the projected experience of the members projected to be enrolled in health benefit plans through
3761 the certified group purchasing cooperative relative to the projected experience of the members
3762 projected to be enrolled in health benefit plans outside the certified group purchasing
3763 cooperative; or

3764 (3) any other rate adjustment factor resulting in a discount of up to 10 per cent.
3765 Any adjustment greater than 10 per cent shall require prior approval in writing from the
3766 commissioner.

3767 SECTION 129. Subsection (e) of section 5 of chapter 176M of the General Laws, as so
3768 appearing, is hereby amended by striking out, in lines 94 to 96, the words “division of health care

3769 finance and policy established under chapter one hundred and eighteen G” and inserting in place
3770 thereof the following words:- institute of health care finance and policy established under chapter
3771 12C.

3772 SECTION 130. Said subsection (e) of said section 5 of said chapter 176M, as so
3773 appearing, is hereby further amended by striking out, in line 99, the word “division” and
3774 inserting in place thereof the following word:- institute.

3775 SECTION 131. Section 1 of chapter 176O of the General Laws, as so appearing, is
3776 hereby amended by inserting after the definition of “Adverse determination” the following
3777 definition:-

3778 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health
3779 care provider for health care services provided to an insured.

3780 SECTION 131A. Said section 1 of said chapter 176O, as so appearing, is hereby further
3781 amended by striking out the definition of “Behavioral health manager” and inserting in place
3782 thereof the following definition:-

3783 “Behavioral health manager”, a company, organized under the law of the commonwealth
3784 or organized under the laws of another state and qualified to do business in the commonwealth,
3785 that has entered into a contractual arrangement with a carrier to provide or arrange for the
3786 provision of behavioral, substance use disorder and mental health services to voluntarily enrolled
3787 member of the carrier.

3788 SECTION 131B. Said section 1 of said chapter 176O, as so appearing, is hereby further
3789 amended by striking out the definition of “Emergency medical condition” and inserting in place
3790 thereof the following definition:-

3791 “Emergency medical condition”, a medical condition, whether physical, behavioral,
3792 related to substance use disorder, or mental, manifesting itself by symptoms of sufficient
3793 severity, including severe pain, that the absence of prompt medical attention could reasonably be
3794 expected by a prudent layperson who possesses an average knowledge of health and medicine, to
3795 result in placing the health of the insured or another person in serious jeopardy, serious
3796 impairment to body function or serious dysfunction of any body organ or part or, with respect to
3797 a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42
3798 U.S.C. section 1395dd(e)(1)(B).

3799 SECTION 131C. Said section 1 of said chapter 176O, as so appearing, is hereby further
3800 amended by striking out the definition of “Health care services” and inserting in place thereof
3801 the following definition:-

3802 “Health care services”, services for the diagnosis, prevention, treatment, cure or relief of
3803 a physical, behavioral, substance use disorder or mental health condition, illness, injury or
3804 disease.

3805 SECTION 132. Said section 1 of said chapter 176O, as so appearing, is hereby further
3806 amended by striking out the definition of “Incentive plan” and inserting in place thereof the
3807 following definition:-

3808 “Incentive plan,” any compensation arrangement between a carrier and licensed health
3809 care professional or registered provider organization or organization that employs or utilizes

3810 services of 1 or more licensed health care professionals that may directly or indirectly have the
3811 effect of reducing or limiting services furnished to insureds of the organization.

3812 SECTION 133. Said section 1 of said chapter 176O, as so appearing, is hereby further
3813 amended by striking out the definition of “Licensed health care provider group”.

3814 SECTION 134. Said section 1 of said chapter 176O, as so appearing, is hereby further
3815 amended by inserting after the definition of “Prospective review” the following 2 definitions:-

3816 “Provider organization,” any corporation, partnership, business trust, association or
3817 organized group of persons whether incorporated or not that consists of or represents 1 or more
3818 providers in contracting with carriers for the payments the provider or providers receive for the
3819 provision of health care services or as further defined in regulations promulgated by the institute
3820 of health care finance and policy under chapter 12C; provided, that “provider organization” shall
3821 include, but not be limited to, physician organizations, physician-hospital organizations,
3822 independent practice associations, provider networks, accountable care organizations and any
3823 other organization that contracts with carriers for payment for health care services.

3824 “Registered provider organization” a provider organization that has been registered under
3825 chapter 12C.

3826 SECTION 135. Section 2 of chapter 176O of the General Laws, as so appearing, is
3827 hereby amended by striking out, in line 22, the word “division” and inserting in place thereof the
3828 following word:- institute.

3829 SECTION 136. Section 5B of said chapter 176O, as so appearing, is hereby amended by
3830 striking out, in lines 11 and 12, the words “the division of health care finance and policy, the

3831 health care quality and cost council” and inserting in place thereof the following words:- the
3832 institute of health care finance and policy.

3833 SECTION 136A. Said chapter 176O is hereby amended by inserting after section 5B the
3834 following section:-

3835 Section 5C. If the commissioner determines that a carrier is neglecting to comply with the
3836 coding standards and guidelines under this chapter in the form and within the time required the
3837 commissioner shall notify the carrier of such neglect. If the carrier does not come into
3838 compliance within a period determined by the commissioner, the carrier shall be fined \$5000 for
3839 each day during which such neglect continues.

3840 SECTION 137. Subsection (a) of section 6 of said chapter 176O, as so appearing, is
3841 hereby amended by striking out clauses (3) and (4) and inserting in place thereof the following 2
3842 clauses:-

3843 (3) the limitations on the scope of health care services and any other benefits to be
3844 provided, including: (i) all restrictions relating to preexisting condition exclusions; (ii) an
3845 explanation of any facility fee, allowed amount, co-insurance, copayment, deductible or other
3846 amount that the insured may be responsible to pay to obtain covered benefits from network or
3847 out-of-network providers; and (iii) a toll-free telephone number and website established by the
3848 carrier that enables consumers to request and obtain from a carrier within 2 working days the
3849 amount the insured will be responsible to pay for a proposed admission, procedure or service that
3850 is a medically necessary covered benefit, based on the information available to the carrier at the
3851 time the request is made, including any facility fee, copayment, deductible or other out of pocket
3852 amount and the actual or maximum estimated allowed amount and co-insurance, for any covered

3853 health care benefits; provided, that the insured shall not be required to pay more than the
3854 disclosed amounts for the covered health care benefits; provided, however, that nothing in this
3855 section shall prevent carriers from imposing cost sharing requirements disclosed in the insured's
3856 evidence of coverage for unforeseen services that arise out of the proposed admission, procedure
3857 or service;

3858 (4) the locations where, and the manner in which, health care services and other benefits
3859 may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or
3860 service that is a medically necessary covered benefit is not available to an insured within the
3861 carrier's network, the carrier shall cover the out-of-network admission, procedure or service and
3862 the insured will not be responsible to pay more than the amount which would be required for
3863 similar admissions, procedures or services offered within the carrier's network; and (ii) an
3864 explanation that whenever a location is part of the carrier's network, that the carrier shall cover
3865 medically necessary covered benefits delivered at that location and the insured shall not be
3866 responsible to pay more than the amount required for network services even if part of the
3867 medically necessary covered benefits are performed by out-of-network providers unless the
3868 insured has a reasonable opportunity to choose to have the service performed by a network
3869 provider;

3870 SECTION 138. Clause (1) of subsection (a) of section 7 of said chapter 176O, as so
3871 appearing, is hereby amended by striking out, in lines 18 and 19, the words "6 of chapter 118G"
3872 and inserting in place thereof the following words:- 11 of chapter 12C.

3873 SECTION 139. Said clause (1) of said subsection (a) of said section 7 of said chapter
3874 176O, as so appearing, is hereby further amended by striking out, in lines 20 and 21, the words

3875 “6 of said chapter 118G” and inserting in place thereof the following words:- 11 of said chapter
3876 12C.

3877 SECTION 140. Subsection (c) of section 9A of said chapter 176O, as so appearing, is
3878 hereby amended by striking out, in line 25, the words “6 of chapter 118G” and inserting in place
3879 thereof the following words:- 11 of chapter 12C; and.

3880 SECTION 141. Said section 9A of said chapter 176O, as so appearing, is hereby further
3881 amended by adding the following 2 subsections:-

3882 (d) limits the ability of either the carrier or the health care provider from disclosing the
3883 allowed amount and fees of services to an insured or insured’s treating health care provider.

3884 (e) limits the ability of either the carrier or the health care provider from disclosing out-
3885 of-pocket costs to an insured.

3886 SECTION 142. Subsection (a) of section 10 of said chapter 176O, as so appearing, is
3887 hereby amended by striking out, in line 2, the word “health”.

3888 SECTION 143. Said subsection (a) of said section 10 of said chapter 176O, as so
3889 appearing, is hereby further amended by inserting after the word “group”, in line 2, the following
3890 words:- or registered provider organization.

3891 SECTION 144. Section 12 of said chapter 176O, as so appearing, is hereby amended by
3892 striking out subsection (a) and inserting in place thereof the following subsection:-

3893 (a) Utilization review conducted by a carrier or a utilization review organization shall be
3894 conducted under a written plan, under the supervision of a physician and staffed by appropriately
3895 trained and qualified personnel and shall include a documented process to: (i) review and

3896 evaluate its effectiveness; (ii) ensure the consistent application of utilization review criteria; and
3897 (iii) ensure the timeliness of utilization review determinations. The disclosure of utilization
3898 review criteria required by this section shall not apply to licensed, proprietary criteria purchased
3899 by a carrier or utilization review organization.

3900 A carrier or utilization review organization shall adopt utilization review criteria and
3901 conduct all utilization review activities under said criteria. The criteria shall be, to the maximum
3902 extent feasible, scientifically derived and evidence-based, and developed with the input of
3903 participating physicians, consistent with the development of medical necessity criteria under
3904 section 16. Utilization review criteria shall be applied consistently by a carrier or a utilization
3905 review organization and made easily accessible and up-to-date on a carrier or utilization review
3906 organization's website to subscribers, health care providers and the general public. If a carrier or
3907 utilization review organization intends either to implement a new preauthorization requirement
3908 or restriction or amend an existing requirement or restriction, the carrier or utilization review
3909 organization shall ensure that the new or amended requirement or restriction shall not be
3910 implemented unless the carrier's or utilization review organization's website has been updated to
3911 reflect the new or amended requirement or restriction.

3912 Adverse determinations rendered by a program of utilization review or other denials of
3913 requests for health services, shall be made by a person licensed in the appropriate specialty
3914 related to such health service and, if applicable, by a provider in the same licensure category as
3915 the ordering provider.

3916 SECTION 145. Said section 12 of said chapter 176O, as so appearing, is hereby further
3917 amended by adding the following subsection:-

3918 (f) Upon request by an insured or insured's treating health care provider, a carrier or
3919 utilization review organization shall make a determination regarding whether a proposed
3920 admission, procedure or service is medically necessary within 2 working days of obtaining all
3921 necessary information, except that a carrier or utilization review organization may choose not to
3922 perform such a review if the carrier or utilization review organization determines that the
3923 admission, procedure or service will be covered. Nothing in this subsection shall require a
3924 treating health care provider to obtain information regarding whether a proposed admission,
3925 procedure or service is medically necessary on behalf of an insured. Nothing in this subsection
3926 shall restrict the ability of a carrier or utilization review organization to deny a claim for an
3927 admission, procedure or service if the admission, procedure or service was not medically
3928 necessary, based on information provided at the time of claim. Nothing in this subsection shall
3929 restrict the ability of a carrier or utilization review organization to deny a claim for an admission,
3930 procedure or service if other terms and conditions of coverage are not met at the time of service
3931 or time of claim.

3932 SECTION 146. Section 15 of said chapter 176O, as so appearing, is hereby amended by
3933 striking out, in lines 2, 3, 5 and 6, 6, 9, 22, 25, 27, 46 and 47, 47, 49, 52, 60, 71 and 74, the word
3934 "physician" and inserting in place thereof, in each instance, the following word:- provider.

3935 SECTION 147. Section 16 of said chapter 176O, as so appearing, is hereby amended by
3936 striking out subsection (b) and inserting in place thereof the following subsection:-

3937 (b) A carrier shall be required to pay for health care services ordered by a treating
3938 physician or a primary care provider if: (1) the services are a covered benefit under the insured's
3939 health benefit plan; and (2) the services are medically necessary. A carrier may develop

3940 guidelines to be used in applying the standard of medical necessity, as defined in this subsection.
3941 Any such medical necessity guidelines utilized by a carrier in making coverage determinations
3942 shall be: (i) developed with input from practicing physicians and participating providers in the
3943 carrier's or utilization review organization's service area; (ii) developed under the standards
3944 adopted by national accreditation organizations; (iii) updated at least biennially or more often as
3945 new treatments, applications and technologies are adopted as generally accepted professional
3946 medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier
3947 shall consider the individual health care needs of the insured. Any such medical necessity
3948 guidelines criteria shall be applied consistently by a carrier or a utilization review organization
3949 and made easily accessible and up-to-date on a carrier or utilization review organization's
3950 website to subscribers, health care providers and the general public. If a carrier or utilization
3951 review organization intends either to implement a new medical necessity guideline or amend an
3952 existing requirement or restriction, the carrier or utilization review organization shall ensure that
3953 the new or amended requirement or restriction shall not be implemented unless the carrier's or
3954 utilization review organization's website has been updated to reflect the new or amended
3955 requirement or restriction.

3956 SECTION 148. Subsection (c) of section 21 of said chapter 176O, as so appearing, is
3957 hereby amended by striking out, in lines 109 and 110, the words "division of health care finance
3958 and policy for use under section 6 of chapter 118G" and inserting in place thereof the following
3959 words:- institute of health care finance and policy for use under section 10 of chapter 12C.

3960 SECTION 149. Said section 21 of said chapter 176O, as so appearing, is hereby further
3961 amended by striking out subsection (d) and inserting in place thereof the following 2
3962 subsections:-

3963 (d) If a carrier reports a risk-based capital ratio on a combined entity basis under
3964 subsection (a) that exceeds 700 per cent, the division shall hold a public hearing within 60 days
3965 of receiving such report. The carrier shall submit testimony on how the carrier will dedicate any
3966 additional surplus above the 700 per cent level to reducing the cost of health benefit plans or for
3967 health care quality improvement, patient safety or health cost containment programs consistent
3968 with the activities of the health care quality and finance authority. The division shall review such
3969 testimony and issue a final report on the results of the hearing.

3970 (e) The commissioner may waive specific reporting requirements in this section for
3971 classes of carriers for which the commissioner deems such reporting requirements to be
3972 inapplicable; provided, however, that the commissioner shall provide written notice of any such
3973 waiver to the joint committee of health care financing and the house and senate committees on
3974 ways and means.

3975 SECTION 150. Said chapter 176O is hereby amended by adding the following 4
3976 sections:-

3977 Section 22. No carrier shall enter or renew an agreement or contract with any provider
3978 organization that is not registered under chapter 12C. Nothing herein shall require a carrier to
3979 negotiate a network contract with a registered provider organization, or with a registered
3980 provider organization for all providers that are part of, or represented by, a registered provider
3981 organization.

3982 Section 23. A provider organization registered under section 10 of chapter 12C which
3983 utilizes alternative payment methodologies, as defined in section 1 of said chapter 12C, shall
3984 create an internal appeals process. The internal appeals process shall be available to the public in

3985 a written format and by request in electronic format. The internal appeals process shall be
3986 completed in 14 days from the filing of the appeal; provided, that an expedited internal appeal
3987 process shall be completed in 3 days for a patient with a terminal illness or in emergency
3988 situations, as defined by regulations promulgated by the department of public health. The
3989 decision on the appeal shall be in writing and shall notify the patient of the right to file a further
3990 external appeal.

3991 The department of public health shall establish by regulation an external review process
3992 for the review of grievances submitted by or on behalf of patients of provider organizations
3993 registered under section 10 of chapter 12C utilizing alternative payment methodologies. The
3994 process shall specify the maximum amount of time for the completion of a determination and
3995 review after a grievance is submitted and shall include the right to have benefits continued
3996 pending appeal. The department shall establish expedited review procedures applicable to
3997 emergency and urgent care situations Section 24. (a) A payer or any entity acting for a payer
3998 under contract, when requiring prior authorization for a health care service or benefit, shall use
3999 and accept only the prior authorization forms designated for the specific types of services and
4000 benefits developed under subsection (c).

4001 (b) If a payer or any entity acting for a payer under contract fails to use or accept the
4002 required prior authorization form, or fails to respond within 2 business days after receiving a
4003 completed prior authorization request from a provider, pursuant to the submission of the prior
4004 authorization form developed as described in subsection (c), the prior authorization request shall
4005 be deemed to have been granted.

4006 (c) The division shall develop and implement uniform prior authorization forms for
4007 different health care services and benefits. The forms shall cover such health care services and
4008 benefits including, but not limited to, provider office visits, prescription drug benefits, imaging
4009 and other diagnostic testing, laboratory testing and any other health care services. The division
4010 shall develop forms for different kinds of services as it deems necessary or appropriate; provided
4011 that, all payers and any entities acting for a payer under contract shall use the uniform form
4012 designated by the division for the specific type of service. Six months after the full set of forms
4013 has been developed, every provider shall use the appropriate uniform prior authorization form to
4014 request prior authorization for coverage of the health care service or benefit and every payer or
4015 any entity acting for a payer under contract shall accept the form as sufficient to request prior
4016 authorization for the health care service or benefit.

4017 (d) The prior authorization forms developed under subsection (c) shall:

4018 (1) not exceed 2 pages;

4019 (2) be made electronically available; and

4020 (3) be capable of being electronically accepted by the payer after being
4021 completed.

4022 (e) The division, in developing the forms, shall:

4023 (1) seek input from interested stakeholders and shall seek to use forms that have
4024 been mutually agreed upon by payers and providers;

4025 (2) ensure that the forms are consistent with existing prior authorization forms
4026 established by the federal Centers for Medicare and Medicaid Services; and

4027 (3) consider other national standards pertaining to electronic prior authorization.

4028 (f) Nothing in this section shall limit a health plan from requiring prior authorization for
4029 services.

4030 Section 25. The division shall promulgate regulations under which a carrier may move
4031 members into and out of different payment methodologies, including, but not limited to, different
4032 product types, without mutual agreement from the participating provider.

4033 SECTION 151. Section 1 of chapter 176Q of the General Laws, as appearing in the 2010
4034 Official Edition, is hereby amended by inserting after the definition of “connector seal of
4035 approval” the following definition:-

4036 “Dependent”, the spouse and children of any employee if such persons would qualify for
4037 dependent status under the Internal Revenue Code or for whom a support order could be granted
4038 under chapters 208, 209 or 209C.

4039 SECTION 152. Said section 1 of said chapter 176Q, as so appearing, is hereby further
4040 amended by striking out the definition of “division”.

4041 SECTION 153. Said section 1 of said chapter 176Q, as so appearing, is hereby further
4042 amended by inserting after the definition of “eligible small groups” the following 2 definitions:-

4043 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
4044 ends in the calendar year by which it is identified.

4045 “Free care”, the following medically necessary services provided to individuals
4046 determined to be financially unable to pay for their care, in whole or in part, under applicable
4047 regulations of the connector: (1) services provided by acute hospitals; (2) services provided by

4048 community health centers; and (3) patients in situations of medical hardship in which major
4049 expenditures for health care have depleted or can reasonably be expected to deplete the financial
4050 resources of the individual to the extent that medical services cannot be paid, as determined by
4051 regulations of the connector.

4052 SECTION 154. Said section 1 of said chapter 176Q, as so appearing, is hereby further
4053 amended by inserting after the definition of “mandated benefits” the following 2 definitions:-

4054 “Medically necessary services”, medically necessary inpatient and outpatient services as
4055 mandated under Title XIX of the Federal Social Security Act; provided, that “medically
4056 necessary services” shall not include: (1) non-medical services, such as social, educational and
4057 vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone
4058 conversations and consultations; (5) court testimony; (6) research or the provision of
4059 experimental or unproven procedures including, but not limited to, treatment related to sex-
4060 reassignment surgery, and pre-surgery hormone therapy; and (7) the provision of whole blood;
4061 and provided, however, that administrative and processing costs associated with the provision of
4062 blood and its derivatives shall be payable.

4063 “Non-providing employer”, an employer of a state-funded employee, as defined in this
4064 section; provided, however, that the term “non-providing employer” shall not include:—

4065 (i) an employer who complies with chapter 151F for such employee;

4066 (ii) an employer that is signatory to or obligated under a negotiated, bona fide
4067 collective bargaining agreement between such employer and bona fide employee representative
4068 which agreement governs the employment conditions of such person receiving free care;

4069 (iii) an employer who participates in the insurance reimbursement program; or

4070 (iv) an employer that employs not more than 10 employees.

4071 For the purposes of this definition, an employer shall not be considered to pay for or
4072 arrange for the purchase of health care services provided by acute hospitals and ambulatory
4073 surgical centers by making or arranging for any payments to the uncompensated care pool.

4074 SECTION 155. Said section 1 of said chapter 176Q, as so appearing, is hereby further
4075 amended by inserting after the definition of “participating institution” the following definition:-

4076 “Payments from non-providing employers”, all amounts paid to the Uncompensated Care
4077 Trust Fund or the General Fund or any successor fund by non-providing employers.

4078 SECTION 156. Said section 1 of said chapter 176Q, as so appearing, is hereby further
4079 amended by inserting after the definition of “rating factor” the following definition:-

4080 “State-funded employee”, any employed person, or dependent of such person, who
4081 receives, on more than 3 occasions during any hospital fiscal year, health services paid for as free
4082 care; or any employed persons, or dependents of such persons, of a company that has 5 or more
4083 occurrences of health services paid for as free care by all employees in aggregate during any
4084 fiscal year; provided that an occurrence shall include all healthcare related services incurred
4085 during a single visit to a health care professional.

4086 SECTION 157. Said section 1 of said chapter 176Q, as so appearing, is hereby further
4087 amended by inserting after the definition of “sub-connector” the following definition:-

4088 “Uninsured patient”, a patient who is not covered by a health insurance plan, a self-
4089 insurance health plan or a medical assistance program.

4090 SECTION 158. Subsection (m) of section 3 of chapter 176Q of the General Laws, as
4091 appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 84 and 85, the
4092 words “the board deems necessary to implement chapters 111M, 118G and 118H” and inserting
4093 in place thereof the following words:- , departments, commissions, authorities or political
4094 subdivisions the board considers necessary or appropriate to implement chapters 111M, 118E,
4095 118H and this chapter.

4096 SECTION 159. Said section 3 of said chapter 176 Q, as so appearing, is hereby further
4097 amended by adding the following subsection:-

4098 (u) to enter into contracts or agreements, at the board’s discretion, with state departments,
4099 agencies, commissions, authorities, political subdivisions or any individuals, groups, non-profit
4100 or not-for-profit corporations, organizations or associations that are seeking affordable health
4101 insurance; provided further, that the connector shall serve as an agent or advisor to assist with or
4102 procure health insurance for said entities or persons. The board shall give preference to assisting
4103 non-profit or not-for-profit corporations or individuals, groups, organizations or associations
4104 seeking the connector’s assistance for populations that have been historically uninsured or
4105 underinsured.

4106 SECTION 160. Chapter 176Q of the General Laws is hereby amended by striking out
4107 section 7A and inserting in place thereof the following section:-

4108 Section 7A. (a) There shall be a small group wellness incentive pilot program to expand
4109 the prevalence of employee wellness initiatives by small businesses. The program shall be
4110 administered by the board of the connector, in consultation with the department of public health.
4111 The program shall provide subsidies and technical assistance for eligible small groups to

4112 implement evidence-based employee health and wellness programs to improve employee health,
4113 decrease employer health costs and increase productivity.

4114 (b) An eligible small group shall be qualified to participate in the program if:

4115 (1) the eligible small group purchases group coverage through the connector;

4116 (2) the eligible small group enrolls in an evidence-based, employee wellness
4117 program offered through the connector;

4118 (3) the eligible small group meets certain minimum criteria, as determined by the
4119 connector board; and

4120 (4) the eligible small group meets certain minimum employee participation
4121 requirements in the qualified wellness program, as determined by the connector board, in
4122 collaboration with the department of public health.

4123 (c) For eligible small groups participating in the program, the connector shall provide an
4124 annual subsidy not to exceed 15 per cent of eligible employer health care costs as calculated by
4125 the connector board. If the director determines that funds are insufficient to meet the projected
4126 costs of enrolling new eligible employers, the director shall impose a cap on enrollment in the
4127 program.

4128 (d) The connector shall report annually to the joint committee on community
4129 development and small business, the joint committee on health care financing and the house and
4130 senate committees on ways and means on the enrollment in the small business wellness incentive
4131 program and evaluate the impact of the program on expanding wellness initiatives for small
4132 groups.

4133 (e) The connector shall promulgate regulations to implement this section.

4134 SECTION 161. Said chapter 176Q is hereby amended by adding the following 2
4135 sections:-

4136 Section 17. (a) The connector shall prepare a form, to be called the employer health
4137 insurance responsibility disclosure, on which an employer shall report whether it is in
4138 compliance with chapter 151F and any other information required by the connector relative to
4139 section 18 and paragraph (4) of subsection (a) of section 69 of chapter 118E. The form shall be
4140 completed, signed and returned to the institute by every employer with 11 or more full-time
4141 equivalent employees.

4142 (b) The connector shall prepare a form, to be called the employee health insurance
4143 responsibility disclosure, on which an employee of employers with 11 or more full-time
4144 equivalent employees who declines an employer-sponsored health plan shall report whether the
4145 employee has an alternative source of health insurance coverage. The form shall be completed
4146 and signed by the employee and shall be retained by the employer for 3 years. The institute may
4147 request a copy of the signed employee form.

4148 (c) Information that indentifies individual employees by name or health insurance status
4149 shall not be a public record, but the information shall be exchanged with the department of
4150 revenue, the commonwealth health insurance connector authority and the health care access
4151 bureau in the division of insurance under an interagency services agreement to enforce this
4152 section, sections 3 to 7A, inclusive and sections 3, 6B and 18B of chapter 118H. An employer
4153 who knowingly falsifies or fails to file with the connector any information required by this

4154 section or by any regulation promulgated by the connector shall be punished by a fine of not less
4155 than \$1,000 not more than \$5,000.

4156 Section 18. (a) The connector shall, upon verification of the provision of services and
4157 costs to a state-funded employee, assess a free rider surcharge on the non-providing employer
4158 under regulations promulgated by the connector.

4159 (b) The amount of the free rider surcharge on non-providing employers shall be
4160 determined by the connector under regulations promulgated by the connector, and assessed by
4161 the connector not later than 3 months after the end of each hospital fiscal year, with payment by
4162 non-providing employers not later than 180 days after the assessment. The amount charged by
4163 the connector shall be greater than 10 per cent but not greater than 100 per cent of the cost to the
4164 state of the services provided to the state-funded employee, considering all payments received by
4165 the state from other financing sources for free care; provided that the “cost to the state” for
4166 services provided to any state-funded employee may be determined by the connector as a
4167 percentage of the state’s share of aggregate costs for health services. The free rider surcharge
4168 shall only be triggered upon incurring \$50,000 or more, in any hospital fiscal year, in free care
4169 services for any employer’s employees, or dependents of such persons, in aggregate, regardless
4170 of how many state-funded employees are employed by that employer.

4171 (c) The formula for assessing free rider surcharges on non-providing employers shall be
4172 set forth in regulations promulgated by the connector that shall be based on factors including, but
4173 not limited to: (i) the number of incidents during the past year in which employees of the non-
4174 providing employer received services reimbursed by the health safety net office under section 69

4175 of chapter 118E; (ii) the number of persons employed by the non-providing employer; (iii) the
4176 proportion of employees for whom the non-providing employer provides health insurance.

4177 (d) If a state-funded employee is employed by more than 1 non-providing employer at the
4178 time the employee receives services, the connector shall assess a free rider surcharge on each
4179 said employer consistent with the formula established by the connector under this section.

4180 (e) The connector shall specify by regulation appropriate mechanisms for implementing
4181 free rider surcharges on non-providing employers. Said regulations shall include, but not be
4182 limited to, the following:—

4183 (i) appropriate mechanisms that provide for determination and payment of
4184 surcharge by a non-providing employer including requirements for data to be submitted by
4185 employers, employees, acute hospitals and ambulatory surgical centers, and other persons; and

4186 (ii) penalties for nonpayment or late payment by the non-providing employer,
4187 including assessment of interest on the unpaid liability at a rate not to exceed an annual
4188 percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per
4189 month.

4190 (f) All surcharge payments made under this section shall be deposited into the
4191 Commonwealth Care Trust Fund, established by section 2000 of chapter 29.

4192 (g) A non-providing employer's liability to that fund shall in the case of a transfer of
4193 ownership be assumed by the successor in interest to the non-providing employer's.

4194 (h) If a non-providing employer fails to file any data, statistics or schedules or other
4195 information required under this chapter or by any regulation promulgated by the connector, the

4196 connector shall provide written notice of the required information. If the employer fails to
4197 provide information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be
4198 subject to a civil penalty of not more than \$5,000 for each week on which such violation occurs
4199 or continues, which penalty may be assessed in an action brought on behalf of the
4200 commonwealth in any court of competent jurisdiction.

4201 (i) The attorney general shall bring any appropriate action, including injunctive relief, as
4202 may be necessary for the enforcement of this section.

4203 (j) No employer shall discriminate against any employee on the basis of the employee's
4204 receipt of free care, the employee's reporting or disclosure of the employer's identity and other
4205 information about the employer, the employee's completion of a Health Insurance Responsibility
4206 Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed
4207 against the employer in relation to the employee. Violation of this subsection shall constitute a
4208 per se violation of chapter 93A.

4209 (k) A hospital, surgical center, health center or other entity that provides health safety net
4210 services shall provide an uninsured patient with written notice of the criminal penalties for
4211 committing fraud in connection with the receipt of health safety net services. The connector shall
4212 promulgate a standard written notice form to be made available to health care providers in
4213 English and foreign languages. The form shall further include written notice of every employee's
4214 protection from employment discrimination under this section.

4215 SECTION 162. The General Laws are hereby amended by inserting, after chapter 176R
4216 the following 2 chapters:

4217 CHAPTER 176S

4218 COMMONWEALTH HEALTH CARE QUALITY AND FINANCE AUTHORITY

4219 Section 1. As used in this chapter the following words shall, unless the context clearly
4220 requires otherwise, have the following meanings:-

4221 “Actual economic growth benchmark,” the actual annual percentage change in the per
4222 capita state’s gross state product, excluding the impact of business cycles, as established under
4223 section 7H½ of chapter 29.

4224 “Acute hospital,” the teaching hospital of the University of Massachusetts Medical
4225 School and any hospital licensed under section 51 of chapter 111 and which contains a majority
4226 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of
4227 public health.

4228 “Alternative payment contract”, any contract between a provider or provider organization
4229 and a public health care payer or a private health care payer which utilizes alternative payment
4230 methodologies.

4231 “Alternative payment methodologies”, methods of payment that are not directly fee-for-
4232 service reimbursement for services; provided, that “alternative payment methodologies” may
4233 include, but not be limited to, global payments, shared savings arrangements, bundled payments
4234 and episodic payments.

4235 “Authority”, the commonwealth health care quality and finance authority.

4236 “Beacon ACO”, a certification given by the board of the authority to indicate that a
4237 provider organization meets certain standards regarding quality, cost containment and patient
4238 protection.

4239 “Board”, the board of the commonwealth health care quality and finance authority,
4240 established by section 2.

4241 “Business entity”, a corporation, association, partnership, limited liability company,
4242 limited liability partnership or other legal entity.

4243 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health
4244 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
4245 176A; a nonprofit medical service corporation organized under chapter 176B; a health
4246 maintenance organization organized under chapter 176G; and an organization entering into a
4247 preferred provider arrangement under chapter 176I, but not including an employer purchasing
4248 coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or
4249 affiliated corporations of the employer; provided that, unless otherwise noted, the term “carrier”
4250 shall not include any entity to the extent it offers a policy, certificate or contract that provides
4251 coverage solely for dental care services or visions care services.

4252 “Facility,” a licensed institution providing health care services or a health care setting,
4253 including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical
4254 or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory
4255 and imaging centers and rehabilitation and other therapeutic health settings.

4256 "Fee-for-service", a form of contract under which a provider or provider organization is
4257 paid for discrete and separate units of service and each provider is separately reimbursed for each
4258 discrete service rendered to a patient; provided, however, that up to 20 per cent of total
4259 reimbursement under such contracts may depend on the achievement of certain targets of
4260 performance or conduct.

4261 “Institute”, the institute of health care finance and policy established in chapter 12C.

4262 “Health benefit plan”, any individual, general, blanket or group policy of health, accident
4263 and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service
4264 plan issued by a non-profit hospital service corporation under chapter 176A; a group medical
4265 service plan issued by a non-profit medical service corporation under chapter 176B; a group
4266 health maintenance contract issued by a health maintenance organization under chapter 176G; a
4267 coverage for young adults health insurance plan under section 10 of chapter 176J; provided that
4268 “health benefit plan” shall not include accident only, credit-only, limited scope vision or dental
4269 benefits if offered separately, hospital indemnity insurance policies if offered as independent,
4270 non-coordinated benefits which for the purposes of this chapter shall mean policies issued under
4271 chapter 175 which provide a benefit not to exceed \$500 per day, as adjusted on an annual basis
4272 by the amount of increase in the average weekly wages in the commonwealth as defined in
4273 section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an
4274 insured, on the basis of a hospitalization of the insured or a dependent, disability income
4275 insurance, coverage issued as a supplement to liability insurance, specified disease insurance that
4276 is purchased as a supplement and not as a substitute for a health plan and meets any requirements
4277 the commissioner of insurance by regulation may set, insurance arising out of a workers
4278 compensation law or similar law, automobile medical payment insurance, insurance under which
4279 benefits are payable with or without regard to fault and which is statutorily required to be
4280 contained in a liability insurance policy or equivalent self insurance, long-term care if offered
4281 separately, coverage supplemental to the coverage provided under 10 U.S.C. section 55 if offered
4282 as a separate insurance policy, or any policy subject to chapter 176K or any similar policies
4283 issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans;

4284 provided, further that “health benefit plan” shall not include a health plan issued, renewed or
4285 delivered within or without the commonwealth to an individual who is enrolled in a qualifying
4286 student health insurance program under section 18 of chapter 15A which shall be governed by
4287 said chapter 15A; provided, further that the authority may by regulation define other health
4288 coverage as a health benefit plan for the purposes of this chapter.

4289 “Health care cost growth benchmark,” the projected annual percentage change in total
4290 health care expenditures in the commonwealth, as established in section 5.

4291 “Health care entity”, a provider, provider organization or carrier.

4292 “Health care professional,” a physician or other health care practitioner licensed,
4293 accredited or certified to perform specified health services consistent with law.

4294 “Health care services,” services for the diagnosis, prevention, treatment, cure or relief of
4295 a physical, behavioral, substance use disorder or mental health condition, illness, injury or
4296 disease.

4297 “Health status adjusted total medical expenses”, the total cost of care for the patient
4298 population associated with a provider group based on allowed claims for all categories of
4299 medical expenses and all non-claims related payments to providers, adjusted by health status and
4300 expressed on a per member per month basis, as calculated under section 9 of chapter 12C.

4301 “Major service category,” a set of service categories to be established by regulation,
4302 which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii)
4303 outpatient and ambulatory services, by categories as defined by the Centers for Medicare and
4304 Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all

4305 other” outpatient and ambulatory services that do not fall within a defined category; (iii)
4306 behavioral substance use disorder and mental health services by categories as defined by the
4307 Centers for Medicare and Medicaid, or as established by regulation; (iv) professional services, by
4308 categories as defined by the Centers for Medicare and Medicaid, or as established by regulation;
4309 and (v) sub-acute services, by major service line or clinical offering, as defined by regulation.

4310 “Medicaid program”, the medical assistance program administered by the division of
4311 medical assistance under chapter 118E and in accordance with Title XIX of the Federal Social
4312 Security Act or any successor statute.

4313 “Medicare program”, the medical insurance program established by Title XVIII of the
4314 Social Security Act.

4315 “Net cost of private health insurance,” the difference between health premiums earned
4316 and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as
4317 included in medical loss ratio regulations promulgated by the division of insurance; (ii) net
4318 additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise
4319 defined by regulations promulgated by the institute under chapter 12C.

4320 “Performance improvement plan,” a plan submitted to the authority by a carrier, a
4321 provider or a provider organization under section 7, which shall be kept confidential by the board
4322 and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4
4323 or chapter 66.

4324 “Projected economic growth benchmark,” the long-term average projected percentage
4325 chance in the per capita state’s gross state product, excluding the impact of business cycles, as
4326 established under section 7H½ of chapter 29.

4327 “Provider,” a health care professional or a facility.

4328 “Provider organization,” any corporation, partnership, business trust, association or
4329 organized group of persons whether incorporated or not that consists of or represents 1 or more
4330 providers in contracting with carriers for the payments the provider or providers receive for the
4331 provision of health care services or as further defined in regulations promulgated by the institute
4332 of health care finance and policy under chapter 12C; provided, that “provider organization” shall
4333 include, but not be limited to, physician organizations, physician-hospital organizations,
4334 independent practice associations, accountable care organizations, provider networks and any
4335 other organization that contracts with carriers for payment for health care services.

4336 “Specialty hospital,” an acute hospital which qualifies for an exemption from the
4337 Medicare prospective payment system regulations or any acute hospital which limits its
4338 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to
4339 children or patients under obstetrical care.

4340 “Total health care expenditures”, the annual per capita sum of all health care expenditures
4341 in the commonwealth from public and private sources, including: (i) all categories of medical
4342 expenses and all non-claims related payments to providers, as included in the health status
4343 adjusted total medical expenses reported by the institute under subsection (d) of section 9 of
4344 chapter 12C; (ii) all patient cost-sharing amounts, such as, deductibles and copayments; and (iv)
4345 the net cost of private health insurance, or as otherwise defined by the institute in regulations
4346 promulgated under said chapter 12C.

4347 Section 2. (a) There shall be a body politic and corporate and a public instrumentality to
4348 be known as the commonwealth health care quality and finance authority, which shall be an

4349 independent public entity not subject to the supervision and control of any other executive office,
4350 department, commission, board, bureau, agency or political subdivision of the commonwealth
4351 except as specifically provided in any general or special law. The exercise by the authority of the
4352 powers conferred by this chapter shall be considered to be the performance of an essential public
4353 function. The purpose of the authority shall be to set health care cost containment goals for the
4354 commonwealth and to foster innovative health care delivery and payment models that lower
4355 health care cost growth while improving the quality of patient care.

4356 (b) There shall be a board, with duties and powers established by this chapter, that shall
4357 govern the authority. The authority's board shall consist of 11 members: the secretary of
4358 administration and finance, ex officio; the secretary of health and human services, ex officio; the
4359 secretary of housing and economic development, ex officio; 1 other member appointed by the
4360 governor whom shall be an expert in health care delivery and payment models; 3 members
4361 appointed by the attorney general, 1 of whom shall be a health economist, 1 of whom shall
4362 represent the interests of businesses and 1 of whom shall have experience in the administration
4363 of a health care provider organization; 3 members appointed by the state auditor, 1 of whom
4364 shall be an expert in behavioral substance use disorder and mental health services and behavioral
4365 substance use disorder and mental health reimbursement systems, 1 of whom shall be a
4366 representative of a health consumer organization and 1 of whom shall be a representative of
4367 organized labor. The governor, attorney general and the auditor shall, by majority vote, jointly
4368 appoint 1 member who is an expert in health care finance and policy in the commonwealth, to act
4369 as the chair. All members shall serve a term of 3 years, but a member appointed to fill a vacancy
4370 shall serve only for the unexpired term. An appointed member of the board shall be eligible for
4371 reappointment. The board shall annually elect 1 of its members to serve as the vice-chairperson.

4372 Each member of the board serving ex officio may appoint a designee under section 6A of chapter
4373 30.

4374 (c) A member of the board shall not be employed by, a consultant to, a member of the
4375 board of directors of, affiliated with, have a financial stake in or otherwise be a representative of
4376 a health care entity while serving on the board.

4377 (d) Six members of the board shall constitute a quorum and the affirmative vote of 6
4378 members of the board shall be necessary and sufficient for any action taken by the board. No
4379 vacancy in the membership of the board shall impair the right of a quorum to exercise all the
4380 rights and duties of the connector. Members shall serve without pay but shall be reimbursed for
4381 actual expenses necessarily incurred in the performance of their duties. The chairperson of the
4382 board shall report to the governor and to the general court not less frequently than annually.

4383 (e) Any action of the authority may take effect immediately and need not be published or
4384 posted unless otherwise provided by law. Meetings of the board shall be subject to sections 18 to
4385 25, inclusive, of chapter 30A; but, said sections 18 to 25, inclusive, shall not apply to any
4386 meeting of members of the board serving ex officio in the exercise of their duties as officers of
4387 the commonwealth if no matters relating to the official business of the authority are discussed
4388 and decided at the meeting. The authority shall be subject to all other provisions of said chapter
4389 30A and records pertaining to the administration of the authority shall be subject to section 42 of
4390 chapter 30 and section 10 of chapter 66. All moneys of the authority shall be considered to be
4391 public funds for purposes of chapter 12A. The operations of the authority shall be subject to
4392 chapter 268A and chapter 268B.

4393 (f) The chairperson shall hire an executive director to supervise the administrative affairs
4394 and general management and operations of the authority and also serve as secretary of the
4395 authority, ex officio. The executive director shall receive a salary commensurate with the duties
4396 of the office. The executive director may appoint other officers and employees of the authority
4397 necessary to the functioning of the authority. Sections 9A, 45, 46 and 46C of chapter 30, chapter
4398 31 and chapter 150E shall not apply to the executive director of the authority. The executive
4399 director shall, with the approval of the board:

4400 (i) plan, direct, coordinate and execute administrative functions in conformity
4401 with the policies and directives of the board;

4402 (ii) employ professional and clerical staff as necessary;

4403 (iii) report to the board on all operations under the executive director's control
4404 and supervision;

4405 (iv) prepare an annual budget and manage the administrative expenses of the
4406 authority; and

4407 (v) undertake any other activities necessary to implement the powers and duties
4408 under this chapter.

4409 Section 3. The board of the authority shall set health care cost containment goals for the
4410 commonwealth and foster the innovation of health care delivery and payment models that lower
4411 health care cost growth while improving the quality of patient care. The board shall have all
4412 powers necessary or convenient to carry out and effectuate its purposes including, but not limited
4413 to, the power to:

4414 (a) to develop a plan of operation for the authority, which shall include, but not be limited
4415 to:

4416 (1) establishing procedures for operations of the authority;

4417 (2) establishing procedures for communications with the executive director;

4418 (3) establishing procedures for setting an annual health care cost growth
4419 benchmark;

4420 (4) holding annual hearings concerning the growth in total health care
4421 expenditures relative to the health care cost growth benchmark, including an examination of
4422 health care provider, provider organization and payer costs, prices and health status adjusted total
4423 medical expense trends;

4424 (5) providing an annual report on recommendations for strategies to meet future
4425 annual health care cost growth benchmarks and to promote an efficient health delivery system;

4426 (6) establishing procedures that, in the event the annual health care cost growth
4427 benchmark is exceeded, require certain health care entities to file a performance improvement
4428 plan and the procedures for approving said plan;

4429 (7) establishing procedures for monitoring compliance and implementation by a
4430 health care entity of a performance improvement plan, including standards to ascertain whether a
4431 health care entity has failed to implement a performance improvement plan in good faith;

4432 (8) establishing procedures and developing criteria for the certification of certain
4433 provider organizations as Beacon ACOs, based on standards related to cost containment, quality
4434 improvement and patient protections;

4435 (9) establishing procedures to decertify certain provider organizations as Beacon
4436 ACOs;

4437 (10) developing best practices and standards for alternative payment
4438 methodologies to be adopted by the office of Medicaid, the group insurance commission and
4439 other state-funded health insurance programs;

4440 (11) fostering health care innovation by identifying, developing, supporting and
4441 evaluating health care delivery and payment reform models and best practices, in consultation
4442 with health care entities, that reduce health care cost growth while improving the quality of
4443 patient care; and

4444 (12) administering the Healthcare Payment Reform Fund, established under
4445 section 100 of chapter 194 of the acts of 2011, to support the activities of the authority;

4446 (b) to adopt by-laws for the regulation of its affairs and the conduct of its business;

4447 (c) to adopt an official seal and alter the same;

4448 (d) to maintain an office at such place or places in the commonwealth as it may
4449 designate;

4450 (e) to sue and be sued in its own name, plead and be impleaded;

4451 (f) to establish lines of credit, and establish 1 or more cash and investment accounts to
4452 receive payments for services rendered, appropriations from the commonwealth and for all other
4453 business activity granted by this chapter except to the extent otherwise limited by any applicable
4454 provision of the Employee Retirement Income Security Act of 1974;

4455 (g) to approve the use of its trademarks, brand names, seals, logos and similar
4456 instruments by participating carriers, employers or organizations; and

4457 (h) to enter into interdepartmental agreements with the institute of health care finance and
4458 policy, the executive office of health and human services, the division of insurance and any other
4459 state agencies the board considers necessary.

4460 Section 4. There shall be an advisory board to the authority. The advisory board shall
4461 advise on the overall operation and policy of the authority. The advisory board shall consist of 7
4462 ex-officio members, including the state auditor, the inspector general, the attorney general, the
4463 commissioner of insurance, the executive director of the institute of health care finance and
4464 policy, the commissioner of public health and the executive director of the group insurance
4465 commission, or their designees; and 15 additional members to be appointed by the governor, 1 of
4466 whom shall be a representative of a health care quality improvement organization recognized by
4467 the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of
4468 the Institute for Healthcare Improvement recommended by the organization's board of directors,
4469 1 of whom shall be a representative of the Massachusetts chapter of the National Association of
4470 Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts
4471 Association of Health Underwriters, Inc., 1 of whom shall be a representative of the
4472 Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy
4473 from a foundation or academic institution, 1 of whom shall be a representative of a non-
4474 governmental purchaser of health insurance, 1 of whom shall be an organization representing the
4475 interests of small businesses with fewer than 50 employees, 1 of whom shall be an organization
4476 representing the interests of large businesses with 50 or more employees, 1 of whom shall be a
4477 physician licensed to practice in the commonwealth and 1 of whom shall be a non-physician

4478 health care professional licensed to practice in the commonwealth; 1 of whom shall be an expert
4479 in racial and ethnic health disparities; 1 of whom shall be a representative of an organization
4480 representing the interests of academic medical centers; 1 of whom shall be a member of
4481 MassMEDIC; and 1 of whom shall be selected from a list of 2 names provided by the President
4482 of the Massachusetts AFL-CIO.

4483 Section 5. (a) Not later than April 15 of every year, the board shall establish a health care
4484 cost growth benchmark for the average growth in total health care expenditures in the
4485 commonwealth for the next calendar year. The authority shall establish procedures to
4486 prominently publish the annual health care cost growth benchmark on the authority's website.

4487 (b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal
4488 to the economic growth benchmark established under section 7H½ of chapter 29, plus 0.5%.

4489 (c) For calendar years 2016 and thereafter, the health care cost growth benchmark shall
4490 be equal to the economic growth benchmark established under section 7H½ of chapter 29.

4491 Section 6. (a) Not later than October 1 of every year, the board shall hold public hearings
4492 based on the report submitted by the institute under section 15 of chapter 12C comparing the
4493 growth in total health care expenditures to the health care cost growth benchmark for the
4494 previous calendar year. The hearings shall examine health care provider, provider organization
4495 and private and public health care payer costs, prices, and cost trends, with particular attention to
4496 factors that contribute to cost growth within the commonwealth's health care system. The
4497 attorney general may intervene in such hearings.

4498 (b) Public notice of any hearing shall be provided at least 60 days in advance.

4499 (c) The authority shall identify as witnesses for the public hearing a representative sample
4500 of providers, provider organizations, payers and others, including: (i) at least 3 academic medical
4501 centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii)
4502 at least 3 disproportionate share hospitals, including the 2 hospitals whose largest per cent of
4503 gross patient service revenue is attributable to Title XVIII and XIX of the federal Social Security
4504 Act or other governmental payers; (iii) community hospitals from at least 3 separate regions of
4505 the state; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the
4506 state; (v) community health centers from at least 3 separate regions of the state; (vi) the 5 private
4507 health care payers with the highest enrollments in the state; (vii) any managed care organization
4508 that provides health benefits under Title XIX or under the commonwealth care health insurance
4509 program; (viii) the group insurance commission; (ix) at least 3 municipalities that have adopted
4510 chapter 32B; (x) at least 3 provider organizations, at least 1 of which shall be a physician
4511 organization and at least 1 of which has been certified as a Beacon ACO; and (xi) any witness
4512 identified by the attorney general or the institute of health care finance and policy.

4513 (d) Witnesses shall provide testimony under oath and subject to examination and cross
4514 examination by the board, the executive director of the institute and the attorney general at the
4515 public hearing in a manner and form to be determined by the board, including without limitation:
4516 (i) in the case of providers and provider organizations, testimony concerning payment systems,
4517 care delivery models, payer mix, cost structures, administrative and labor costs, capital and
4518 technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization
4519 trends, relative price, quality improvement and care-coordination strategies, investments in
4520 health information technology, the relation of private payer reimbursement levels to public payer
4521 reimbursements for similar services, efforts to improve the efficiency of the delivery system and

4522 efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private
4523 and public payers, testimony concerning factors underlying premium cost and rate increases, the
4524 relation of reserves to premium costs, the payer's efforts to develop benefit design, network
4525 design and payment policies that enhance product affordability and encourage efficient use of
4526 health resources and technology including utilization of alternative payment methodologies,
4527 efforts by the payer to increase consumer access to health care information, efforts by the payer
4528 to promote the standardization of administrative practices and any other matters as determined
4529 by the board. The board shall solicit testimony from any payer which has been identified by the
4530 institute's annual report under section 15 of chapter 12C as (i) paying providers more than 10 per
4531 cent above or more than 10 percent below the weighted average relative price or (ii) entering into
4532 alternative payment contracts that vary by more than 10 per cent. Any payer identified by the
4533 institute's report shall explain the extent of price variation between the payer's participating
4534 providers and describe any efforts to reduce such price variation.

4535 (e) In the event that the institute's annual report under section 15 of chapter 12C finds
4536 that the percentage change in total health care expenditures exceeded the health care cost
4537 benchmark in the previous calendar year, the authority may identify additional witnesses for the
4538 public hearing. Witnesses shall provide testimony subject to examination and cross examination
4539 by the board, the executive director of the institute and attorney general at the public hearing in a
4540 manner and form to be determined by the board, including without limitation: (i) testimony
4541 concerning unanticipated events that may have impacted the total health care cost expenditures,
4542 including, but not limited to, a public health crisis such as an outbreak of a disease, a public
4543 safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity
4544 or utilization of services; (iii) testimony concerning trends in input cost structures, including, but

4545 not limited to, the introduction of new pharmaceuticals, medical devices and other health
4546 technologies; (iv) testimony concerning the cost of providing certain specialty services, including
4547 but not limited to, the provision of health care to children, the provision of cancer-related health
4548 care and the provision of medical education; (v) testimony related to unanticipated administrative
4549 costs for carriers, including, but not limited to, costs related to information technology,
4550 administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related
4551 to costs due the implementation of state or federal legislation or government regulation; and (vii)
4552 any other factors that may have led to excessive health care cost growth.

4553 (f) The authority shall compile an annual report concerning spending trends and
4554 underlying factors, along with any recommendations for strategies to increase the efficiency of
4555 the health care system. The report shall be based on the authority's analysis of information
4556 provided at the hearings by providers, provider organizations and insurers, data collected by the
4557 institutes under sections 9, 10 and 11 of chapter 12C, and any other information the authority
4558 considers necessary to fulfill its duties under this section, as further defined in regulations
4559 promulgated by the authority. The report shall be submitted to the chairs of the house and senate
4560 committees on ways and means, the chairs of the joint committee on health care financing and
4561 shall be published and available to the public not later than December 31 of each year. The
4562 report shall include any legislative language necessary to implement the recommendations

4563 Section 7. (a) The authority shall provide confidential notice to health care entities whose
4564 increase in health status adjusted total medical expense is considered excessive and who threaten
4565 the ability of the state to meet the health care cost growth benchmark as identified by the institute
4566 under section 16 of chapter 12C. Such notice shall state that the health care entity has been
4567 identified as having an excessive increase in health status adjusted total medical expense.

4568 (b) For calendar year 2015, in the event that the institute's annual report under section 15
4569 of chapter 12C finds that average percentage change in cumulative total health care expenditures
4570 from 2012 to 2014 exceeded the average health care cost growth benchmark from 2012 to 2014,
4571 and in order to support the state's efforts to meet future health care cost growth benchmarks, as
4572 established in section 5, the authority shall establish procedures to assist health care entities to
4573 improve efficiency and reduce cost growth through the requirement of certain health care entities
4574 to file and implement a performance improvement plan.

4575 Beginning in calendar year 2016, in the event that the institute's annual report under said
4576 section 15 of said chapter 12C finds that percentage change in total health care expenditures
4577 exceeded the health care cost growth benchmark in the previous calendar year, and in order to
4578 support the state's efforts to meet future health care cost growth benchmarks, as established in
4579 said section 5, the authority shall establish procedures to assist health care entities to improve
4580 efficiency and reduce the cost growth through the requirement of certain health care entities to
4581 file and implement a performance improvement plan.

4582 (c) In addition to the confidential notice provided under subsection (a), the authority may
4583 provide confidential notice to the health care entity that it will be required to file a performance
4584 improvement plan. Within 45 days of receiving this notice from the authority, the health care
4585 entity shall either:

4586 (1) file a confidential performance improvement plan with the authority; or

4587 (2) file a confidential application with the authority to waive or extend the
4588 requirement to file a performance improvement plan. The health care entity may file any
4589 documentation or supporting evidence with the authority to support the health care entity's

4590 application to waive or extend the requirement to file a performance improvement plan. The
4591 authority shall require the health care entity to submit any other relevant information it deems
4592 necessary in considering the waiver or extension application.

4593 All information submitted shall remain confidential and exempt from disclosure under
4594 clause Twenty-sixth of section 7 of chapter 4 and chapter 66.

4595 (d) The authority may waive or delay the requirement for a health care entity to file a
4596 performance improvement plan in response to a waiver or extension request filed under
4597 paragraph (2) of subsection (c) based on a consideration of the following factors, in light of all
4598 information received from the health care entity:

4599 (1) the costs, price and utilization trends of the health care entity over time, and
4600 any demonstrated improvement to reduce health status adjusted total medical expenses;

4601 (2) any ongoing strategies or investments that the health care entity is
4602 implementing to improve future long-term efficiency and reduce cost growth, including
4603 certification as a Beacon ACO;

4604 (3) whether the factors that led to increased costs for the health care entity can
4605 reasonably be considered to be outside of the control of the entity and unanticipated;

4606 (4) the overall financial condition of the health care entity;

4607 (5) the proportionate impact of the health care entity's costs on the growth of total
4608 health care medical expenses statewide;

4609 (6) a significant deviation between the projected economic growth benchmark and
4610 the actual economic growth benchmark, as established under section 7H½ of chapter 29; and

4611 (7) any other factors the authority considers relevant, including any information or
4612 testimony collected by the authority under the subsection (e) of section 6.

4613 If the authority declines to waive or extend the requirement for the health care entity to
4614 file a performance improvement plan, the authority shall provide confidential notice to the health
4615 care entity that its application for a waiver or extension was denied and the health care entity
4616 shall file a performance improvement plan within 45 days.

4617 (e) A health care entity shall file a performance improvement plan: (i) within 45 days of
4618 receipt of a notice under subsection (c); (ii) if the health care entity has requested a waiver or
4619 extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or
4620 (iii) if the health care entity is granted an extension, on the date given on such extension. The
4621 performance improvement plan shall be generated by the health care entity and shall identify the
4622 causes of the entity's cost growth and shall include, but not be limited to, specific strategies,
4623 adjustments and action steps the entity proposes to implement to improve cost performance, as
4624 measured by health status adjusted total medical expenses. The proposed performance
4625 improvement plan shall include specific identified and measurable expected outcomes and a
4626 timetable for implementation. The timetable for a performance improvement plan shall not
4627 exceed 18 months.

4628 (f) The authority shall approve any performance improvement plan that it determines is
4629 reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable
4630 expectation for successful implementation.

4631 (g) If the board determines that the performance improvement plan is unacceptable or
4632 incomplete, the authority may provide consultation on the criteria that have not been met and

4633 may allow an additional time period, up to 30 calendar days, for resubmission; provided
4634 however, that all aspects of the performance improvement plan shall be proposed by the health
4635 care entity and the authority shall not require specific elements for approval.

4636 (h) Upon approval of the proposed performance improvement plan, the authority shall
4637 notify the health care entity to begin immediate implementation of the performance improvement
4638 plan. Public notice shall be provided by the authority on its website identifying that the health
4639 care entity is implementing a performance improvement plan; provided however, that the
4640 performance improvement plan itself shall remain confidential. All health care entities
4641 implementing an approved performance improvement plan shall be subject to additional
4642 confidential reporting requirements and compliance monitoring, as determined by the authority.
4643 The authority shall provide assistance to the health care entity in the successful implementation
4644 of the performance improvement plan.

4645 (i) All health care entities shall, in good faith, work to implement the performance
4646 improvement plan. At any point during the implementation of the performance improvement
4647 plan the health care entity may file amendments to the performance improvement plan, subject to
4648 approval of the authority.

4649 (j) At the conclusion of the timetable established in the performance improvement plan,
4650 the health care entity shall report to the authority regarding the outcome of the performance
4651 improvement plan. If the performance improvement plan was found to be unsuccessful, the
4652 authority shall either: (i) extend the implementation timetable of the existing performance
4653 improvement plan; (ii) approve amendments to the performance improvement plan as proposed
4654 by the health care entity; (iii) require the health care entity to submit a new performance

4655 improvement plan under subsection (e); or (iv) waive or delay the requirement to file any
4656 additional performance improvement plans.

4657 (k) Upon the successful completion of the performance improvement plan, or a decision
4658 by the board to waive or delay the requirement to file a new performance improvement plan, the
4659 identity of the health care entity shall be removed from the authority's website.

4660 (l) If the authority determines that a health care entity has: (i) willfully neglected to file a
4661 performance improvement plan with the authority within 45 days as required under subsection
4662 (e); (ii) failed to file an acceptable performance improvement plan in good faith with the
4663 authority; (iii) failed to implement the performance improvement plan in good faith; or (iv)
4664 knowingly failed to provide information required by this section to the authority or that
4665 knowingly falsifies the same, the authority may assess a civil penalty to the health care entity of
4666 not more than \$500,000. The authority shall seek to promote compliance with this section and
4667 shall only impose a civil penalty as a last resort.

4668 (m) The authority may submit a recommendation of proposed legislation to the joint
4669 committee on health care financing if the authority believes that further legislative authority is
4670 needed to assist health care entities to implement successful performance improvement plans or
4671 to ensure compliance under this section.

4672 (n) The authority shall promulgate regulations as necessary to implement this section;
4673 provided however, that notice of any proposed regulations shall be filed with the joint committee
4674 on state administration and the joint committee on health care financing at least 180 days before
4675 adoption.

4676 Section 8. (a) The authority, in consultation with the advisory board, shall develop
4677 standards and a common application form for certain provider organizations to be voluntarily
4678 certified as Beacon ACOs. The purpose of the Beacon ACO certification process shall be to
4679 encourage the adoption of certain best practices by provider organizations in the commonwealth
4680 related to cost containment, quality improvement and patient protection. Provider organizations
4681 seeking this certification shall apply directly to the authority and shall submit all necessary
4682 documentation as required by the authority. The Beacon ACO certification shall be assigned to
4683 all provider organizations that meet the standards developed by the board.

4684 (b) In developing standards for Beacon ACO certification, the authority shall review the
4685 best practices employed by health care entities in the commonwealth and the standards included
4686 in models developed by the Centers for Medicare & Medicaid Services, including the Pioneer
4687 ACO, the Medicare Shared Savings Model and any safety net accountable care organization
4688 models, and shall include, at a minimum, a requirement that all Beacon ACOs shall: (i) commit
4689 to entering alternative payment methodology contracts with other purchasers; (ii) be a legal
4690 entity with its own tax identification number, recognized and authorized under the laws of the
4691 commonwealth; (iii) include patient and consumer representation on its governance; and (iv)
4692 commit to ensuring at least 50 per cent of the Beacon ACO's primary care providers are
4693 meaningfully using certified EHR technology as defined in the HITECH Act and subsequent
4694 Medicare regulations.

4695 (c) The board shall develop additional standards necessary to be certified as a Beacon
4696 ACO, related to quality improvement, cost containment and patient protections. In developing
4697 additional standards, the board shall consider, at a minimum, the following requirements for
4698 Beacon ACOs:

4699 (1) to reduce the growth of health status adjusted total medical expenses over
4700 time, consistent with the state's efforts to meet the health care cost growth benchmark
4701 established under section 5;

4702 (2) to improve the quality of health services provided, as measured by the
4703 statewide quality measure set and other appropriate measures;

4704 (3) to ensure patient access to health care services across the care continuum,
4705 including, but not limited to, access to: preventive and primary care services; emergency
4706 services; hospitalization services; ambulatory patient services; mental health, substance use
4707 disorder and behavioral health services; access to specialty care units, including, but are not
4708 limited to, burn, coronary care, cancer care, including the services of a comprehensive cancer
4709 center, as defined in section 8 of chapter 118E, neonatal care, post-obstetric and post operative
4710 recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care
4711 units; pediatric services;obstetrics and gynecology services; diagnostic imaging and screening
4712 services; clinical laboratory and pathology services; maternity and newborn care services and
4713 related mental health outcomes; radiation therapy and treatment services; skilled nursing
4714 facilities; family planning services; home health services; treatment and prevention services for
4715 alcohol and other drug abuse; breakthrough technologies and treatments; allied health services
4716 including, but not limited to, advance practice nurses, optometric care, direct access to
4717 chiropractic services and physical therapy, occupational therapists, dental care, midwifery
4718 services, and end-of-life care services, including hospice and palliative care; and establishing
4719 mechanisms to protect patient provider choice, including parameters for out of Beacon
4720 ACOarrangements;

4721 (4) to accept and promote alternative payment methodologies consistent with the
4722 standards developed by the authority under section 9 and the adoption of payment incentives
4723 that improve quality and care coordination, including, but not limited to, incentives to reduce
4724 avoidable hospitalizations, avoidable readmissions, adverse events and unnecessary emergency
4725 room visits; incentives to reduce racial, ethnic and linguistic health disparities in the patient
4726 population; and in all cases ensuring that alternative payment methodologies do not create any
4727 incentive to deny or limit medically necessary care, especially for patients with high risk factors
4728 or multiple health conditions;

4729 (5) to improve access to certain primary care services, including but not limited to, by
4730 having a demonstrated primary care and care coordination capacity and a minimum number of
4731 practices engaged in becoming patient centered medical homes;

4732 (6) to improve access to health care services and quality of care for vulnerable
4733 populations including, but not limited to, children, the elderly, low-income individuals,
4734 individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities,
4735 including demonstrating an ability to provide culturally and linguistically appropriate care,
4736 patient education and outreach provided by community health workers.

4737 (7) to promote the integration of mental health, substance use disorder and
4738 behavioral, substance use disorder and mental health services with primary care services
4739 including, but not limited to, the establishment of a behavioral health medical home, recovery
4740 coaching and peer support and services provided by peer support workers, certified peer
4741 specialists and licensed alcohol and drug counselors;

4742 (8) to promote patient-centeredness by, including, but not limited to, establishing
4743 mechanisms to conduct patient outreach and education on the necessity and benefits of care
4744 coordination, including group visits and chronic disease self-management programs;
4745 demonstrating an ability to engage patients in shared decision making taking into account patient
4746 preferences; demonstrating an ability to effectively involve patients in care transitions to improve
4747 the continuity and quality of care across settings, with case manager follow up; demonstrating an
4748 ability to engage and activate patients at home, through methods such as home visits or
4749 telemedicine, to improve self-management; establishing mechanisms to evaluate patient
4750 satisfaction with the access and quality of their care; establishing mechanisms between payers
4751 and the provider organization such that any shared savings between the provider and the payer
4752 shall contain a mechanism to return a percentage of the savings to the Beacon ACO participants;
4753 and establishing mechanisms to protect patient provider choice, including parameters for
4754 accessing care outside of the provider organization;

4755 (9) to adopt certain health information technology, data analysis functions and
4756 performance management programs, including, but not limited to, population-based management
4757 tools and functions; data stratification by sex and sex-race groups; the ability to aggregate and
4758 analyze clinical data; the ability to electronically exchange patient summary records across
4759 providers who are members of the Beacon ACO and other providers in the community to ensure
4760 continuity of care; the ability to provide access to multi-payer claims data and performance
4761 reports and the ability to share performance feedback on a timely basis with participating
4762 providers; the ability to enable the beneficiary access to electronic health information; and the
4763 utilization of a proven performance management program, including, but not limited to,
4764 participation in the 2011-2012 Health Care Criteria for Performance Excellence as developed in

4765 conjunction with the Baldrige Criteria for Performance Excellence administered by the National
4766 Institutes of Standards and Technology of the United States Department of Commerce;

4767 (10) to demonstrate excellence in the area of quality improvement and care
4768 coordination, as evidenced by the success of previous or existing care coordination, pay for
4769 performance, patient centered medical home, quality improvement or health outcomes
4770 improvement initiatives, including, but not limited to, a demonstrated commitment to reducing
4771 avoidable hospitalizations, adverse events and unnecessary emergency room visits;

4772 (11) to adopt protocols to promote provider integration, both with providers
4773 within and outside of the provider organization, including, but not limited to, clinical integration
4774 of the medical director of the laboratory, accredited or certified under the federal Clinical
4775 Laboratory Improvements Act of 1988, providing these services to the organization;

4776 (12) to promote community-based wellness programs and community health
4777 workers, consistent with efforts funded by the department of public health through the
4778 Prevention and Wellness Trust Fund established in section 2G of chapter 111 and to promote
4779 other activities that integrate community public health interventions with an emphasis on the
4780 social determinants of health and which have been proven to improve health;

4781 (13) to promote worker training programs and skills training opportunities for
4782 employees of the provider organization, consistent with efforts funded by the secretary of labor
4783 and workforce development through the Health Care Workforce Transformation Trust Fund;

4784 (14) to adopt certain governance structure standards, including standards related
4785 to financial conflicts of interest and transparency;

4786 (15) to adopt certain financial capacity standards, including certification under
4787 subsection (e) of section 10 of chapter 12C, to protect Beacon ACOs from assuming excess risk;
4788 and

4789 (16) to demonstrate the administrative, clinical and financial capability to meet the
4790 primary and secondary care needs of a defined population of patients, consisting of a minimum
4791 number of covered lives, as established by the authority;

4792 (17) any other requirements the board considers necessary.

4793 (d) The authority shall update the standards for certification as a Beacon ACO at least
4794 every 2 years, or at such other times as the authority determines necessary. In developing the
4795 standards, the authority shall seek to allow for provider organizations of different compositions,
4796 including, but not limited to, hospital and physician organizations, physician group entities and
4797 independent physician organizations, to successfully apply for certification. The authority may
4798 waive certain Beacon ACO financial capacity standards for provider organizations composed of
4799 safety net providers, including community hospitals, high Medicaid disproportionate share
4800 hospitals and their affiliated providers, if the authority determines that such standards represent
4801 an insurmountable barrier to successful certification. The Authority shall not deny a Beacon
4802 ACO certification based solely on the geographic location or size of the provider organization.

4803 (e) Provider organizations seeking to maintain certification shall renew their certification
4804 as a Beacon ACO every 2 years. Failure to meet the requirements represented in the certification
4805 may result in decertification, as determined by the board.

4806 Section 9. The authority, in consultation with the advisory board, shall develop best
4807 practices and standards for alternative payment methodologies for use by the group insurance

4808 commission, the office of Medicaid and any other state funded insurance program. Any
4809 alternative payment methodology shall: (1) support the state's efforts to meet the health care cost
4810 benchmark established in section 5; (2) include incentives for high quality, coordinated care,
4811 including wellness services, primary care services and behavioral health services; (3) include a
4812 risk adjustment element based on health status; (4) to the extent possible, include a risk
4813 adjustment element that takes into account functional status, socioeconomic status or cultural
4814 factors; (5) preserve the use of intergovernmental transfer financing mechanisms by the
4815 governmental acute public hospital consistent with the Medical Assistance Trust Fund provisions
4816 in effect as of fiscal year 2012; and (6) recognize the unique circumstances of high Medicaid
4817 disproportionate share hospitals and other safety net providers with concentrated care in
4818 government programs. The authority shall also consider methodologies to account for the
4819 following costs: (i) medical education; (ii) stand-by services and emergency services, including,
4820 but not limited to, trauma units and burn units; ; (iii) services provided by disproportionate share
4821 hospitals or other providers serving underserved populations, including but not limited to, groups
4822 which suffer adverse health outcomes based on race, sex, ethnicity, disability, housing type,
4823 income level, primary language or educational attainment; (iv) services provided to children; (v)
4824 research; (vi) care coordination and community based services provided by allied health
4825 professionals, including, but not limited to, community health workers, legal advocates, medical
4826 interpreters, clinical prevention specialists, human services workers, social workers and licensed
4827 alcohol and drug counselors; (vii) the greater integration of behavioral, substance use disorder
4828 and mental health; (viii) the use and the continued advancement of new medical technologies,
4829 treatments, diagnostics or pharmacology products that offer substantial clinical improvements
4830 and represent a higher cost than the use of current therapies; (ix) culturally and linguistically

4831 appropriate services; (x) interpreter services; (xi) dedicated care management responsibilities and
4832 administrative responsibilities in alternative payment methodologies; and (xii) costs associated
4833 with the services of a comprehensive cancer center, as defined in section 8 of chapter 118E.

4834 Any best practices and standards developed under this section shall be shared with all
4835 private health plans for their voluntary adoption.

4836 Section 10. (a) The authority, in consultation with the advisory board, shall administer the
4837 Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of
4838 2011. The fund shall be used for the following purposes: (1) to support the activities of the
4839 authority; and (2) to foster innovation in payment and health care service delivery.

4840 (b) The authority shall establish a competitive process for health care entities to develop,
4841 implement, or evaluate promising models in payment and health care service delivery.
4842 Assistance from the authority may take the form of incentives, grants, technical assistance,
4843 evaluation assistance or partnerships, as determined by the authority.

4844 (c) Prior to making a request for proposals under subsection (b), the authority shall solicit
4845 ideas for payment changes and health care delivery service reforms directly from providers,
4846 provider organizations, carriers, research institutions, health professionals, public institutions of
4847 higher education, community-based organizations and private-public partnerships, or any
4848 combination thereof. The authority shall review payment and service delivery models so
4849 submitted and shall seek input from other relevant stakeholders in evaluating their potential.

4850 (d) The authority shall consider proposals that achieve the following goals: (i) to support
4851 safety-net provider and disproportionate share hospital participation in new payment and health
4852 care service delivery models; (ii) to support the successful implementation of performance

4853 improvement plans by health care entities under section 7; (iii) to support cooperative effort
4854 between representatives of employees and management that are focused on controlling costs and
4855 improving the quality of care through workforce engagement; (iv) to support the evaluation of
4856 mobile health and connected health technologies to improve health outcomes among under-
4857 served patients with chronic diseases; and (v) to develop the capacity to safely and effectively
4858 treat chronic, common and complex diseases in rural and underserved areas and to monitor
4859 outcomes of those treatments.

4860 (e) All approved activities funded through the Healthcare Payment Reform Fund shall
4861 support the commonwealth's efforts to meet the health care cost growth benchmark established
4862 under section 5, and shall include measurable outcomes in both cost reduction and quality
4863 improvement.

4864 (f) To the maximum extent feasible, the authority shall seek to coordinate expenditures
4865 from the Healthcare Payment Reform Fund with other public expenditures from the Prevention
4866 and Wellness Trust Fund, the e-Health Institute Trust Fund, the Health Care Workforce
4867 Transformation Trust Fund, the Distressed Community Hospital Fund, the executive office of
4868 health and human services, any funding available through the Medicare program and the CMS
4869 Innovation Center, established under the federal Patient Protection and Affordable Care Act and
4870 any funding expended under the Delivery System Transformation Initiative Master Plan and
4871 hospital-specific plans approved in the MassHealth section 1115 demonstration waiver.

4872 (g) Activities funded through the Healthcare Payment Reform Fund which demonstrates
4873 measurable success in improving care or reducing costs shall be shared with other providers,
4874 provider organizations and payers as model programs which may be voluntarily adopted by such

4875 other health care entities. The authority may also incorporate any successful models and
4876 practices into its standards for the Beacon ACO certification under section 8 and for alternative
4877 payment methodologies established for state-funded programs under section 9.

4878 (h) The authority shall, annually on or before January 31, report on expenditures from the
4879 Healthcare Payment Reform Fund. The report shall include, but not be limited to: (i) the revenue
4880 credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs
4881 of the authority; (iii) an itemized list of the funds expended through the competitive process and
4882 a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of
4883 the activities funded through grants. The report shall be provided to the chairs of the house and
4884 senate committees on ways and means and the joint committee on health care financing and shall
4885 be posted on the authority's website.

4886 Section 11. (a) All expenses incurred in carrying out this chapter shall be payable solely
4887 from funds provided under the authority of this chapter and no liability or obligations shall be
4888 incurred by the authority under this chapter beyond the extent to which monies shall have been
4889 provided under this chapter.

4890 (b) The authority shall be liable on all claims made as a result of the activities, whether
4891 ministerial or discretionary, of any member, officer or employee of the authority acting as such,
4892 except for willful dishonesty or intentional violation of the law, in the same manner and to the
4893 same extent as a private person under like circumstances; provided, however, that the authority
4894 shall not be liable to levy or execution on any real or personal property to satisfy judgment, for
4895 interest prior to judgment, for punitive damages or for any amount in excess of \$100,000.

4896 (c) No person shall be liable to the commonwealth, to the authority or to any other person
4897 as a result of the person's activities, whether ministerial or discretionary, as a member, officer or
4898 employee of the authority except for willful dishonesty or intentional violation of the law;
4899 provided, however, that such person shall provide reasonable cooperation to the authority in the
4900 defense of any claim. Failure of such person to provide reasonable cooperation shall cause such
4901 person to be jointly liable with the authority, to the extent that such failure prejudiced the defense
4902 of the action.

4903 (d) The authority may indemnify or reimburse any person, or a person's personal
4904 representative, for losses or expenses, including legal fees and costs, arising from any claim,
4905 action, proceeding, award, compromise, settlement or judgment resulting from such person's
4906 activities, whether ministerial or discretionary, as a member, officer or employee of the
4907 authority; provided, that the defense of settlement thereof shall have been made by counsel
4908 approved by the authority. The authority may procure insurance for itself and for its members,
4909 officers and employees against liabilities, losses and expenses which may be incurred by virtue
4910 of this section or otherwise.

4911 (e) No civil action under this chapter shall be brought more than 3 years after the date
4912 upon which the cause thereof accrued.

4913 (f) Upon dissolution, liquidation or other termination of the authority, all rights and
4914 properties of the authority shall pass to and be vested in the commonwealth, subject to the rights
4915 of lien holders and other creditors. In addition, any net earnings of the authority, beyond that
4916 necessary for retirement of any indebtedness or to implement the public purpose or purposes or

4917 program of the commonwealth, shall not inure to the benefit of any person other than the
4918 commonwealth.

4919 Section 12. The authority shall keep an accurate account of all its activities and of all its
4920 receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year
4921 to its board, to the governor, to the general court and to the state auditor, such reports to be in a
4922 form prescribed by the board, with the written approval of the auditor. The board or the auditor
4923 may investigate the affairs of the authority, may severally examine the properties and records of
4924 the authority and may prescribe methods of accounting and the rendering of periodical reports in
4925 relation to projects undertaken by the authority. The authority shall be subject to biennial audit
4926 by the state auditor.

4927 Section 13. The authority may adopt regulations to implement this chapter.

4928 CHAPTER 176T

4929 CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

4930 Section 1. As used in this chapter, the following words shall, unless the context clearly
4931 requires otherwise, have the following meanings:

4932 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health
4933 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
4934 176A; a nonprofit medical service corporation organized under chapter 176B; a health
4935 maintenance organization organized under chapter 176G; an organization entering into a
4936 preferred provider arrangement under chapter 176I; a contributory group general or blanket
4937 insurance for persons in the service of the commonwealth under chapter 32A; a contributory

4938 group general or blanket insurance for persons in the service of counties, cities, towns and
4939 districts and their dependents under chapter 32B; the medical assistance program administered
4940 by the office of Medicaid under chapter 118E and under Title XIX of the Social Security Act or
4941 any successor statute; and any other medical assistance program operated by a governmental unit
4942 for persons categorically eligible for such program.

4943 “Commissioner”, the commissioner of insurance.

4944 “Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a
4945 carrier.

4946 “Nondiscriminatory basis”, a carrier shall be providing coverage on a non-discriminatory
4947 basis if its plan does not contain any annual or lifetime dollar or unit of service limitation
4948 imposed on coverage for the care provided by a physician assistant which is less than any annual
4949 or lifetime dollar or unit of service limitation imposed on coverage for the same services by other
4950 participating providers.

4951 “Participating provider”, a provider who, under terms and conditions of a contract with
4952 the carrier or with its contractor or subcontractor, has agreed to provide health care services to an
4953 insured with an expectation of receiving payment, other than coinsurance, co-payments or
4954 deductibles, directly or indirectly, from the carrier.

4955 “Physician assistant”, a person who is a graduate of an approved program for the training
4956 of physician assistants who is supervised by a registered physician under sections 9C to 9H,
4957 inclusive, of chapter 112, and who has passed the Physician Assistant National Certifying Exam
4958 or its equivalent.

4959 “Primary care provider”, a health care professional qualified to provide general medical
4960 care for common health care problems who (i) supervises, coordinates, prescribes or otherwise
4961 provides or proposes health care services; (ii) initiates referrals for specialist care and
4962 chiropractic care; and (iii) maintains continuity of care within the scope of practice.

4963 Section 2. The commissioner and the group insurance commission shall require that all
4964 carriers recognize physician assistants as participating providers subject to section 3 and shall
4965 include coverage on a nondiscriminatory basis to their insureds for care provided by physician
4966 assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall
4967 include benefits for primary care, intermediate care and inpatient care, including care provided in
4968 a hospital, clinic, professional office, home care setting, long-term care setting, mental health or
4969 substance abuse program, or any other setting when rendered by a physician assistant who is a
4970 participating provider and is practicing within the scope of the physician assistant’s professional
4971 authority as defined by statute, rule and physician delegation to the extent that such policy or
4972 contract currently provides benefits for identical services rendered by a provider of health care
4973 licensed by the commonwealth.

4974 Section 3. A participating provider physician assistant practicing within the scope of the
4975 physician assistant’s license, including all regulations requiring collaboration with or supervision
4976 by a physician under section 9E of chapter 112, shall be considered qualified within the carrier’s
4977 definition of primary care provider to an insured.

4978 Section 4. Notwithstanding any general or special law to the contrary, a carrier that
4979 requires the designation of a primary care provider shall provide its insured with an opportunity
4980 to select a participating provider physician assistant as a primary care provider.

4981 Section 5. Notwithstanding any general or special law to the contrary, a carrier shall
4982 ensure that all participating provider physician assistants are included on any publicly accessible
4983 list of participating providers for the carrier.

4984 Section 6. A complaint for noncompliance against a carrier shall be filed with and
4985 investigated by the commissioner or the group insurance commission, whichever shall have
4986 regulatory authority over the carrier. The commissioner and the group insurance commission
4987 shall promulgate regulations to implement this chapter.

4988 SECTION 163. Clause (5) of subsection (d) of section 8A of chapter 180 of the General
4989 Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 100
4990 and 101, the words “division of health care finance and policy pursuant to chapter 118G” and
4991 inserting in place thereof the following words:- institute of health care finance and policy under
4992 chapter 12C.

4993 SECTION 164. Subsection (a) of section 9 of chapter 209C of the General Laws, as so
4994 appearing, is hereby amended by striking out, in lines 36 and 37, the words “the division of
4995 medical assistance or division of health care finance and policy” and inserting in place thereof
4996 the following words:- the office of Medicaid or the executive office of health and human
4997 services.

4998 SECTION 165. Section 60K of chapter 231 of the General Laws, as so appearing, is
4999 hereby amended by striking out, in line 14, the figure “4” and inserting in place thereof the
5000 following figure:- 2.

5001 SECTION 166. Said chapter 231 is hereby amended by inserting after section 60K, the
5002 following section:-

5003 Section 60L. (a) Except as provided in this section, a person shall not commence an
5004 action against a provider of health care as defined in the seventh paragraph of section 60B unless
5005 the person has given the health care provider written notice under this section of not less than
5006 182 days before the action is commenced.

5007 (b) The notice of intent to file a claim required under subsection (a) shall be mailed to the
5008 last known professional business address or residential address of the health care provider who is
5009 the subject of the claim.

5010 (c) The 182 day notice period in subsection (a) shall be shortened to 90 days if:

5011 (1) the claimant has previously filed the 182 day notice required against another
5012 health care provider involved in the claim; or

5013 (2) the claimant has filed a complaint and commenced an action alleging medical
5014 malpractice against 1 or more of the health care providers involved in the claim.

5015 (d) The 182 day notice of intent required in subsection (a) shall not be required if the
5016 claimant did not identify and could not reasonably have identified a health care provider to
5017 which notice shall be sent as a potential party to the action before filing the complaint;

5018 (e) The notice given to a health care provider under this section shall contain, but need
5019 not be limited to, a statement including:

5020 (1) the factual basis for the claim;

5021 (2) the applicable standard of care alleged by the claimant;

5022 (3) the manner in which it is claimed that the applicable standard of care was
5023 breached by the health care provider;

5024 (4) the alleged action that should have been taken to achieve compliance with the
5025 alleged standard of care;

5026 (5) the manner in which it is alleged the breach of the standard of care was the
5027 proximate cause of the injury claimed in the notice; and

5028 (6) the names of all health care providers that the claimant is notifying under this
5029 section in relation to a claim.

5030 (f) Not later than 56 days after giving notice under this section, the claimant shall allow
5031 the health care provider receiving the notice access to all of the medical records related to the
5032 claim that are in the claimant's control and shall furnish release for any medical records related
5033 to the claim that are not in the claimant's control, but of which the claimant has knowledge.
5034 This subsection shall not restrict a patient's right of access to the patient's medical records under
5035 any other law.

5036 (g) Within 150 days after receipt of notice under this section, the health care provider or
5037 authorized representative against whom the claim is made shall furnish to the claimant or the
5038 claimant's authorized representative a written response that contains a statement including the
5039 following:

5040 (1) the factual basis for the defense, if any, to the claim;

5041 (2) the standard of care that the health care provider claims to be applicable to the
5042 action;

5043 (3) the manner in which it is claimed by the health care provider that there was or
5044 was not compliance with the applicable standard of care; and

5045 (4) the manner in which the health care provider contends that the alleged
5046 negligence of the health care provider was or was not a proximate cause of the claimant's alleged
5047 injury or alleged damage.

5048 (h) If the claimant does not receive the written response required under subsection (g)
5049 within the required 150 day time period, the claimant may commence an action alleging medical
5050 malpractice upon the expiration of the 150 day time period. If a provider fails to respond within
5051 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other
5052 means then interest on any judgment against that provider shall accrue and be calculated from
5053 the date that the notice was filed rather than the date that the suit is filed. At any time before the
5054 expiration of the 150 day period, the claimant and the provider may agree to an extension of the
5055 150 day period.

5056 (i) If at any time during the applicable notice period under this section a health care
5057 provider receiving notice under this section informs the claimant in writing that the health care
5058 provider does not intend to settle the claim within the applicable notice period, the claimant may
5059 commence an action alleging medical malpractice against the health care provider, so long as the
5060 claim is not barred by the statute of limitations or repose.

5061 (j) A lawsuit against a health care provider filed within 6 months of the statute of
5062 limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any
5063 claimant, shall be exempt from compliance with this section.

5064 (k) Nothing in this section shall prohibit the filing of suit at any time in order to seek
5065 court orders to preserve and permit inspection of tangible evidence.

5066 SECTION 167. Section 85K of said chapter 231, as appearing in the 2010 Official
5067 Edition, is hereby amended by inserting, in line 8, after the word “costs”, the following words:-

5068 ; provided, however, in the context of medical malpractice claims against a non-profit
5069 charity providing health care, such cause of action shall not exceed the sum of \$100,000,
5070 exclusive of interest and costs.

5071 SECTION 168. Chapter 233 of the General Laws is hereby amended by inserting after
5072 section 79K, the following new section:-

5073 Section 79L. (a) As used in this section, the following words shall, unless the context
5074 clearly requires otherwise, have the following meanings:

5075 “Facility”, a hospital, clinic, or nursing home licensed under chapter 111, a psychiatric
5076 facility licensed under chapter 19 or a home health agency; provided, that “facility” shall also
5077 include any corporation, professional corporation, partnership, limited liability company, limited
5078 liability partnership, authority or other entity comprised of such facilities.

5079 “Health care provider”, any of the following health care professionals licensed under
5080 chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, dental
5081 hygienist, optometrist, nurse, nurse practitioner, physician assistant, chiropractor, psychologist,
5082 independent clinical social worker, speech-language pathologist, audiologist, marriage and
5083 family therapist or mental health counselor; provided, that “health care provider” shall also

5084 include any corporation, professional corporation, partnership, limited liability company, limited
5085 liability partnership, authority, or other entity comprised of such health care providers.

5086 “Unanticipated outcome”, the outcome of a medical treatment or procedure, whether or
5087 not resulting from an intentional act, that differs from an intended result of such medical
5088 treatment or procedure.

5089 (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly
5090 experiencing an unanticipated outcome of medical care, any and all statements, affirmations,
5091 gestures, activities or conduct expressing benevolence, regret, apology, sympathy,
5092 commiseration, condolence, compassion, mistake, error or a general sense of concern which are
5093 made by a health care provider, facility or an employee or agent of a health care provider or
5094 facility, to the patient, a relative of the patient or a representative of the patient and which relate
5095 to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative
5096 proceeding, unless the maker of the statement, or a defense expert witness, when questioned
5097 under oath during the litigation about facts and opinions regarding any mistakes or errors that
5098 occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in
5099 which case the statements and opinions made about the mistake or error shall be admissible for
5100 all purposes. In situations where a patient suffers an unanticipated outcome with significant
5101 medical complication resulting from the provider’s mistake, the health care provider, facility or
5102 an employee or agent of a health care provider or facility shall fully inform the patient, and when
5103 appropriate the patient's family, about said unanticipated outcome.

5104 SECTION 169. Clause (2) of subsection (b) of section 3 of chapter 258C of the General
5105 Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out sub-clause

5106 (A) and inserting in place thereof the following sub-clause:- (A) Expenses incurred for hospital
5107 services as the direct result of injury to the victim shall be compensable under this chapter;
5108 provided, however, that when claiming compensation for hospital expenses, the claimant shall
5109 demonstrate an out-of-pocket loss or a legal liability for payment of said expenses. No hospital
5110 expenses shall be paid if the expense is reimbursable by Medicaid or if the services are covered
5111 by chapter 118E. Every claim for compensation for hospital services shall include a certification
5112 by the hospital that the services are not reimbursable by Medicaid and that the services are not
5113 covered by chapter 118E. In no event shall the amounts awarded for hospital services exceed the
5114 rates for services established by the executive office of health and human services or a
5115 governmental unit designated by the executive office if rates have been established for such
5116 services.

5117 SECTION 170. The second paragraph of section 4 of chapter 260 of the General Laws,
5118 as so appearing, is hereby amended by adding the following sentence:-

5119 The statutes of limitation and repose in this paragraph shall be tolled for a period of 180
5120 days when a notice of intent to file a claim, under subsection (a) of section 60L of chapter 231, is
5121 sent to a provider of health care as defined in the seventh paragraph of section 60B of chapter
5122 231.

5123 SECTION 170A. Section 271 of chapter 127 of the acts of 1999 is hereby amended by
5124 inserting in the first paragraph after the words “the secretary of the executive office of elder
5125 affairs” the following words:- , the executive director of the commonwealth health insurance
5126 connector authority.

5127 SECTION 170B. The first paragraph of said section 271 of said chapter 127 is hereby
5128 further amended by striking out the words “(i) participants in the Senior Pharmacy program, so-
5129 called, pursuant to section 16B of chapter 118E of the General Laws” and inserting in place
5130 thereof the following words:- (i) enrollees in Commonwealth Care under chapter 176Q of the
5131 General Laws.

5132 SECTION 170C. The first paragraph of section 62 of chapter 177 of the acts of 2001 is
5133 hereby amended by inserting after the words “the commissioner of the group insurance
5134 commission” the following words: - ,the executive director of the commonwealth health
5135 insurance connector authority.

5136 SECTION 170D. Section 16 of chapter 257 of the acts of 2008, as most recently
5137 amended by section 27 of chapter 9 of the acts of 2011, is hereby amended by striking out the
5138 words “section 7 of chapter 118G” and inserting in place thereof the following words:- section
5139 13D of chapter 118E.

5140 SECTION 170E. Section 17 of said chapter 257, as most recently amended by section 28
5141 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words “section 7 of
5142 chapter 118G” and inserting in place thereof the following words:- section 13D of chapter 118E.

5143 SECTION 170F. Section 18 of said chapter 257, as most recently amended by section 29
5144 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words “section 7 of
5145 chapter 118G” and inserting in place thereof the following words:- “section 13D of chapter
5146 118E.

5147 SECTION 171. Section 15 of chapter 305 of the acts of 2008 is hereby repealed.

5148 SECTION 172. Chapter 288 of the acts of 2010 is hereby amended by striking out
5149 section 66 and inserting in place thereof the following section:-

5150 SECTION 66. For small group base rate factors applied under section 3 of chapter 176J
5151 of the General Laws between October 1, 2010 and July 1, 2015, a carrier shall limit the effect of
5152 the application of any single or combination of rate adjustment factors identified in paragraphs
5153 (2) to (6), inclusive, of subsection (a) of said chapter 3 of said chapter 176J that are used in the
5154 calculation of an individual's or small group's premium so that the final annual premium charged
5155 to an individual or small group does not increase by more than an amount established annually
5156 by the commissioner by regulation.

5157 SECTION 173. Section 70 of said chapter 288 is hereby amended by striking out the
5158 figure "2012" and inserting in place thereof the following figure:- 2015.

5159 SECTION 173A. Section 48 of chapter 9 of the acts of 2011 is hereby amended by
5160 striking out the words "section 7 of chapter 118G" and inserting in place thereof the following
5161 words:- section 13D of chapter 118E.

5162 SECTION 173B. (a)There is hereby established and set upon the books of the
5163 commonwealth a separate fund to be known as the Distressed Community Hospital Trust Fund,
5164 which shall be administered by the institute of health care finance and policy established under
5165 chapter 12C of the General Laws. Expenditures from the Distressed Community Hospital Trust
5166 Fund shall be dedicated to efforts to improve and enhance the ability of qualified community
5167 hospitals to serve populations in need more effectively.

5168 (b)The Distressed Community Hospital Trust Fund shall consist of any funds that may
5169 be appropriated or transferred for deposit into the trust fund and any funds provided from other
5170 sources.

5171 (c)The institute shall develop a competitive grant process for awards to be distributed
5172 from said fund to qualified community hospitals. The grant process shall consider, among other
5173 factors: payer mix, uncompensated care, financial health, geographic need and population need.
5174 In assessing financial health, the institute shall take into account days cash on hand, net working
5175 capital and earnings before income tax, depreciation and amortization.

5176 (d)A qualified community hospital shall not include a hospital that is a teaching hospital,
5177 a hospital that is receiving delivery system transformation initiative funds or a hospital whose
5178 relative prices are above the statewide median relative price.

5179 (e)The competitive grant process shall include, at a minimum, a comprehensive uses of
5180 funds proposal and a sustainability plan. As a condition of an award, the institute may require a
5181 qualified community hospital to agree to take steps to increase its sustainability, including
5182 reconfiguration of services, changes in staffing, wages or benefits, changes in governance or a
5183 transfer of ownership.

5184 SECTION 174. Notwithstanding any general or special law to the contrary, the
5185 commissioner of public health, in consultation with the board of registration in medicine, shall
5186 promulgate regulations on or before April 1, 2013 to enforce section 226 of chapter 111 of the
5187 General Laws.

5188 SECTION 175. Notwithstanding any general or special law to the contrary, the
5189 department of public health, in consultation with the division of insurance, shall examine and

5190 study best practices and successful models of private sector wellness and health management
5191 programs in order to create a model wellness guide for payers, employers and consumers. The
5192 department shall also issue a report that identifies those elements of said programs that should be
5193 promoted in support of the state's efforts to meet the health care cost growth benchmark
5194 established under section 5 of chapter 176S.

5195 The model guide shall provide the following information: (i) the importance of healthy
5196 lifestyles, disease prevention, care management and health promotion programs; (ii) financial
5197 and other incentives for brokers, payers and consumers to encourage health and wellness
5198 program offerings for consumers and to expand options for individuals who do not have access
5199 to these programs through their workplace; (iii) benefit designs that tie financial consequences to
5200 health care choices; (iv) use of technology to provide wellness information and services; and (v)
5201 identifying qualitative and quantitative program measures to place real value on program results
5202 and track program effectiveness.

5203 In developing the report and model guide, the secretary shall consult with health care
5204 stakeholders, including but not limited to: employers, including representatives of employers
5205 with more than 50 employees and representatives of employers with less than 50 employees;
5206 providers and provider organizations; health carriers; and consumers. The report, along with any
5207 recommendations, shall be submitted to the joint committee on health care financing, the house
5208 and senate committees on ways and means and the secretary of health and human services by
5209 January 1, 2013. The recommendations shall assist in the development of strategies and
5210 programs supported by the Prevention and Wellness Trust Fund established under section 2G of
5211 chapter 111 of the General Laws.

5212 SECTION 176. Notwithstanding any general or special law or rule or regulation to the
5213 contrary, the commissioner of insurance shall adopt regulations requiring any carrier, as defined
5214 in section 1 of chapter 176O of the General Laws, and their contractors to comply with and
5215 implement the federal Mental Health Parity and Addiction Equity Act of 2008, section 511 of
5216 Public Law 110-343 and applicable state mental health parity laws including, section 22 of
5217 chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter
5218 176B and sections 4, 4B and 4M of chapter 176G of the General Laws. The commissioner of
5219 insurance shall adopt such regulations not later than January 1, 2013. The regulations shall be
5220 implemented as part of any provider contract and any carrier's health benefit plans delivered,
5221 issued, entered into, renewed or amended on or after July 31, 2012.

5222 Starting on July 1, 2013, the commissioner of insurance shall require all carriers and their
5223 contractors, to submit an annual report to the division of insurance and to the attorney general,
5224 which shall be a public record, certifying and outlining how their health benefit plans comply
5225 with the federal Mental Health Parity and Addiction Equity Act, applicable state mental health
5226 parity laws, including said section 22 of said chapter 32A, said section 47B of said chapter 175,
5227 said section 8A of said chapter 176A, said section 4A of said chapter 176B and said sections 4,
5228 4B and 4M of said chapter 176G and this section. The division of insurance may, at the request
5229 of the attorney general or in its own discretion, hold a public hearing relative to a carrier's
5230 annual report.

5231 SECTION 177. Notwithstanding any general or special law or rule or regulation to the
5232 contrary, the office of Medicaid shall adopt regulations requiring any Medicaid health plan and
5233 managed care organization and their health plans and any behavioral health management firm
5234 and third party administrator under contract with a Medicaid managed care organization to

5235 comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008,
5236 section 511 of Public Law 110-343 and applicable state mental health parity laws, including
5237 section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A
5238 of chapter 176B and sections 4, 4B and 4M of chapter 176G of the General Laws. The office of
5239 Medicaid shall adopt such regulations not later than January 1, 2013. The regulations shall be
5240 implemented as part of any provider contracts and any carrier's health benefit plans delivered,
5241 issued, entered into, renewed or amended on or July 31, 2012.

5242 Starting on July 1, 2013, the office of Medicaid shall submit an annual report to the house
5243 and senate chairs of the joint committee on health care financing, the house and senate chairs of
5244 the joint committee on mental health and substance abuse, the clerk of the senate, the clerk of the
5245 house of representatives and the attorney general certifying and outlining how the health benefit
5246 plans under the office of Medicaid, and any of their contractors, comply with the federal Mental
5247 Health Parity and Addiction Equity Act, applicable state mental health parity laws, including
5248 said section 22 of said chapter 32A, said section 47B of said chapter 175, said section 8A of said
5249 chapter 176A, said section 4A of said chapter 176B and said sections 4, 4B and 4M of said
5250 chapter 176G and this section. The office of Medicaid may hold a hearing relative to a health
5251 benefit plan's compliance with this section.

5252 SECTION 178. Notwithstanding any general or special law to the contrary, the board of
5253 registration of medicine, established under section 10 of chapter 13 of the General Laws, shall
5254 promulgate regulations relative to the education and training of physicians in the early disclosure
5255 of adverse events, including, but not limited to, continuing medical education requirements.
5256 Nothing in this section shall affect the total hours of continuing medical education required by
5257 the board, including the number of hours required relative to risk management.

5258 SECTION 178A. Notwithstanding any general or special law to the contrary, the board of
5259 registration in nursing, established under section 13 of chapter 13 of the General Laws, shall
5260 promulgate regulations relative to the education and training of advanced practice nurses
5261 authorized to practice under section 80B of chapter 112, in the early disclosure of adverse events
5262 including, but not limited to, continuing education requirements. Nothing in this section shall
5263 affect the total hours of continuing education required by the board.

5264 SECTION 179. Notwithstanding any general or special law to the contrary, the
5265 department of public health, in consultation with the Betsy Lehman center for patient safety and
5266 medical error reduction, established under section 16E of chapter 6A of the General Laws, shall
5267 create an independent task force to study and reduce the practice of defensive medicine and
5268 medical overutilization in the commonwealth, including but not limited to the overuse of
5269 imaging and screening technologies. At least 1 member of the task force shall be a health care
5270 consumer representative. The task force shall issue a report on the financial and non-financial
5271 impacts of defensive medicine and the impact of overutilization on patient safety. The task force
5272 shall file a report of its study, including its recommendations and drafts of any legislation, if
5273 necessary, by filing the same with the clerks of the senate and house of representatives who shall
5274 forward a copy of the report to the joint committee on public health and the joint committee on
5275 health care financing within 1 year of the effective date of this act.

5276 SECTION 180. Notwithstanding any general or special law to the contrary, to the extent
5277 that the office of Medicaid, the group insurance commission, the commonwealth health
5278 insurance connector authority and any other state funded insurance program determine that
5279 accountable care organizations offer opportunities for cost-effective and high quality care, such
5280 state funded insurance programs shall prioritize provider organizations which have been certified

5281 by the board of the health care quality and finance authority as Beacon ACOs, under section 8 of
5282 chapter 176S, for the delivery of publicly funded health services, provided that such Beacon
5283 ACOs, to the extent possible, assure the continuity of patient care.

5284 SECTION 181. Any provider organization that entered a network contract prior to the
5285 effective date of chapter 12C of the General Laws, which organization receives, or represents
5286 providers who collectively receive, at least \$10,000,000 in annual net patient service revenue
5287 from carriers or third-party administrators or which has entered full-risk contracts or which is
5288 corporately affiliated with a carrier, shall register under section 10 of said chapter 12C not later
5289 than December 1, 2012. Any other provider organization that entered a network contract prior to
5290 the effective date of said chapter 12C and is required under said section 10 of said chapter 12C to
5291 register shall register not later than December 1, 2013.

5292 Notwithstanding any other provision of said chapter 12C, and as a condition of licensure
5293 under chapter 111 of the General Laws, any provider that is part of or represented by a provider
5294 organization that entered a network contract and fails to register under said section 10 of said
5295 chapter 12C shall continue to deliver care under such network contract for the duration of such
5296 contract, or a period of 5 years, whichever is longer, at the contract terms and payment levels in
5297 effect upon the date the provider organization fails to register under said section 10 of said
5298 chapter 12C.

5299 SECTION 182. There shall be a special task force to examine behavioral, substance use
5300 disorder and mental health treatment, service delivery, integration of behavioral health with
5301 primary care and behavioral, substance use disorder and mental health reimbursement systems.
5302 The task force shall consist of 13 members: 1 of whom shall be the commissioner of mental

5303 health, who shall serve as chair; 1 of whom shall be a representative of the Massachusetts
5304 Hospital Association; 1 of whom shall be a representative of the Massachusetts Organization for
5305 Addiction Recovery; 1 of whom shall be a representative of the Massachusetts Recovery Home
5306 Collaborative; 1 of whom shall be a representative of the Massachusetts Association of
5307 Behavioral Health Systems; 1 of whom shall be a representative of the Home Care Alliance of
5308 Massachusetts; 1 of whom shall be a representative of the Children’s Mental Health Campaign; 1
5309 of whom shall be a representative of the Association for Behavioral Healthcare; 1 of whom shall
5310 be a representative of the Massachusetts Chapter of the National Association of Social Workers;
5311 and 4 of whom shall be appointed by the governor: 1 of whom shall be a provider with
5312 experience serving difficult to reach populations; 1 of whom shall be a provider with experience
5313 in serving dually diagnosed patients; 1 of whom shall be a registered nurse; and 1 of whom shall
5314 be a school nurse. In its examination, the task force shall review: (a) the most effective and
5315 appropriate approach to including behavioral, substance use and mental health disorder, and
5316 services in the array of services provided by integrated provider organizations, including
5317 transition planning for providers and maintaining continuity of care; (b) how current prevailing
5318 reimbursement methods and covered behavioral, substance use and mental health benefits may
5319 need to be modified to achieve more cost effective, integrated and high quality behavioral,
5320 substance use and mental health outcomes, particularly with respect to the effects of
5321 cardiovascular disease, diabetes and obesity on patients with serious mental illness; (c) the extent
5322 to which and how payment for behavioral health services should be included under alternative
5323 payment methodologies, including how mental health parity and patient choice of providers and
5324 services could be achieved and the design and use of medical necessity criteria and protocols; (d)
5325 how best to educate all providers to recognize behavioral, substance use and mental health

5326 conditions and make appropriate decisions regarding referral to behavioral health services; and
5327 (e) the unique privacy factors required for the integration of behavioral, substance use and
5328 mental health information into interoperative electronic health records. The task force shall
5329 submit its report, findings and recommendations, along with any proposed legislation and
5330 regulatory changes, to the health care quality and finance authority, the clerks of the senate and
5331 house of representatives, the house and senate chairs of the joint committee on mental health and
5332 substance abuse and the house and senate chairs of the joint committee on health care financing
5333 not later than July 1, 2013.”

5334 SECTION 183. Notwithstanding any general or special law to the contrary, the
5335 department of public health shall submit a health resource plan to the governor and the general
5336 court, as required by section 25A of chapter 111 of the General Laws, not later than January 1,
5337 2014.

5338 SECTION 184. There shall be a special task force to study issues related to the accuracy
5339 of medical diagnosis in the commonwealth called the Massachusetts diagnostic accuracy task
5340 force. The task force shall investigate and report on: (i) the extent to which diagnoses in the
5341 commonwealth are accurate and reliable, including the extent to which different diagnoses and
5342 inaccurate diagnoses arise from the biological differences between the sexes; (ii) the underlying
5343 systematic causes of inaccurate diagnoses; (iii) an estimation of the financial cost to the state,
5344 insurers and employers of inaccurate diagnoses; (iv) the negative impact on patients caused by
5345 inaccurate diagnoses; and (v) recommendations to reduce or eliminate the impact of inaccurate
5346 diagnoses.

5347 The Massachusetts diagnostic accuracy task force shall be comprised of 9 members: 1 of
5348 whom shall be the secretary of health and human services, who shall chair the task force; 1 of
5349 whom shall be the commissioner of public health or a designee; 1 of whom shall be the chair of
5350 the board of registration in medicine or a designee; 1 of whom shall be the chair of the board of
5351 registration in nursing or a designee; and 5 members chosen by the governor, 1 of whom shall be
5352 a provider with experience in the area of diagnostic accuracy, 1 of whom shall be a representative
5353 of a Massachusetts health plan, 1 of whom shall be an employer with experience in
5354 implementing programs to address diagnostic inaccuracy, 1 whom shall represent an
5355 organization based in the commonwealth with experience creating and supporting the
5356 implementation of programs on diagnostic accuracy and value-based benefit design, and 1 of
5357 whom shall be a non-physician health care provider.

5358 SECTION 185. Notwithstanding any general or special law to the contrary, the institute
5359 of health care finance and policy shall, in consultation with the executive office of health and
5360 human services, the department of public health, the office of Medicaid and the division of
5361 insurance, review existing public reporting and data collection requirements for health care
5362 providers, provider organizations and payers. The institute shall identify reporting and data
5363 collection requirements that are unnecessary, duplicative, which could be combined or which
5364 should be transferred to the institute in its role as the primary public health care data repository
5365 for the commonwealth.

5366 The institute shall file the results of its review, together with drafts of legislation, if any,
5367 necessary to carry out its recommendations, by filing the same with the clerks of the house of
5368 representatives and the senate who shall forward a copy of the study to the house and senate

5369 committees on ways and means and the joint committee on health care financing not later than
5370 January 1, 2014.

5371 SECTION 186. Notwithstanding any general or special law to the contrary, beginning not
5372 later than July 1, 2014, the group insurance commission, MassHealth and any other state funded
5373 insurance program shall, to the maximum extent feasible, implement alternative payment
5374 methodologies, as defined in section 1 of chapter 12C. The alternative payment methodologies
5375 shall be developed in consultation with the health care quality and finance authority under
5376 section 8 of chapter 176S and all affected publically funded health plans, including, but not
5377 limited to, the Medicaid managed care organizations. Any alternative payment methodology
5378 shall be consistent with the best practices and standards developed by the health care quality and
5379 finance authority under subsection (a) of section 9 of said chapter 176S.

5380 SECTION 187. Notwithstanding any general or special law to the contrary, the health
5381 care quality and finance authority shall contract with an independent outside organization to
5382 conduct a comprehensive review of the impact of this act, and transformations in the health care
5383 payment system and care delivery system in the commonwealth, on health care consumers, the
5384 health care workforce and the general public.

5385 The review shall include, but not be limited to, an investigation of:

5386 (1) The impact on health care costs, including the extent to which savings have
5387 reduced out-of-pocket costs to individuals and families, health insurance premium costs and
5388 health care costs borne by the commonwealth;

5389 (2) The impact on access to health care services and quality of care in different
5390 regions and for different populations, particularly for children, the elderly, low-income
5391 individuals, individuals with disabilities and other vulnerable populations;

5392 (3) The impact on access and quality of care for specific services, particularly
5393 primary care, behavioral, substance use disorder and mental health services;

5394 (4) The impact on the health care workforce, including, but not limited to, health
5395 care worker recruitment and retention, health care worker shortages, training and education
5396 requirements and job satisfaction; and

5397 (5) The impact on public health, including, but not limited to, reducing the
5398 prevalence of preventable health conditions, improving employee wellness and reducing racial
5399 and ethnic disparities in health outcomes.

5400 The organization shall, to the extent possible, obtain and use data from the institute of
5401 health care finance and policy to conduct its analysis; provided, however, that such data shall be
5402 confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4
5403 of the General Laws.

5404 The health care quality and finance authority shall report the results of such review and
5405 its recommendations, if any, together with drafts of legislation necessary to carry out such
5406 recommendations to the house and senate committees on ways and means, the joint committee
5407 on public health and post the results on the health care quality and finance authority's website
5408 not later than March 31, 2017.

5409 SECTION 188. Notwithstanding any general or special law or rule or regulation to the
5410 contrary, upon the adoption of national electronic prior authorization standards by the National
5411 Council for Prescription Drug Programs, the e-Health Institute shall prepare a report that
5412 identifies the appropriate administrative regulations of the commonwealth that will need to be
5413 promulgated in order to make those standards effective within 12 months of adoption of said
5414 standards by the National Council for Prescription Drug Programs, as well as any steps that
5415 should be taken to integrate information available through the commonwealth's prescription
5416 monitoring program. The institute shall, not later than 6 months after the adoption of such
5417 standards by the National Council for Prescription Drug Programs, submit its report together
5418 with any further recommendations and draft legislative language necessary to carry out its
5419 recommendations to the joint committee on public health, the joint committee on health care
5420 financing and the governor.

5421 SECTION 188A. The secretary of elder affairs, the undersecretary of the department of
5422 housing and community development and the commissioner of the department of public health
5423 shall, in conjunction with other agencies of the commonwealth as necessary, develop a state-
5424 wide plan for the development and maintenance of assisted living facilities, long-term care
5425 facilities, home health agencies and rest homes. The state-wide plan shall include an assessment
5426 of existing and projected need for such facilities across all income levels, available capacity of
5427 existing facilities for tenants at all income levels and projected development of additional
5428 capacity in the next 25 years. The state-wide plan shall also assess any and all means being
5429 utilized for payment by individuals for residence in assisted living facilities and the projected
5430 availability of such means in the future for individuals, at all income levels, from public and
5431 private sources, including, but not limited to, Medicare, Medicaid and private insurers.

5432 The state-wide plan, based on said assessments, shall included strategies to meet the
5433 needs identified in such assessments and to facilitate the availability of assisted living facilities
5434 for individuals of all income levels throughout the commonwealth, including the development
5435 and maintenance of capital infrastructure, program services and public and private sources of
5436 financing assisted living residences for the citizens of the commonwealth. The state-wide plan,
5437 together with any recommendations for legislation necessary to carry out the plan, shall be filed
5438 with the clerks of the senate and the house of representatives not later than 2 years after the
5439 effective date of this act.

5440 SECTION 188B. Notwithstanding any general or special law to the contrary, the office
5441 of Medicaid shall not terminate the coverage of any commonwealth care recipient, if: the office
5442 has requested documentation, including the eligibility review form; the recipient has provided
5443 such documentation on or before the date the office stated, in writing, that such documentation
5444 was to be submitted; and the office has acknowledged receipt of the documentation, until the
5445 office determines the eligibility for benefits based on the submitted information. The director
5446 shall promulgate regulations to ensure the proper implementation of this section.

5447 SECTION 188C. The commonwealth health insurance connector authority shall
5448 investigate and study the financial implications of non-residents to contributing employers under
5449 section 188 of chapter 149 of the General Laws. The study shall include an analysis of the
5450 amount of non-resident employees enrolled in employer sponsored health insurance plans, those
5451 non-resident employees not enrolled in employer sponsored plans and the extent to which non-
5452 residents contribute to assessments upon employers pursuant to section 188 of chapter 149 of the
5453 general laws. The study shall consider any current adverse impacts from non-residents
5454 participating in employer-sponsored plans and include recommendations to prevent such adverse

5455 impacts. The authority shall submit a report to the clerks of the house of representatives and
5456 senate, the joint committee on health care financing and the house and senate committee on ways
5457 and means before June 30, 2013.

5458 SECTION 189. There shall be a special commission to review public payer
5459 reimbursement rates and payment systems for health care services and the impact of such rates
5460 and payment systems on health care providers and on health insurance premiums in the
5461 commonwealth. The commission shall consist of 11 members: 1 of whom shall be the secretary
5462 of health and human services or a designee, who shall serve as chair; 1 of whom shall be the
5463 director of the office of Medicaid; 1 of whom shall be the executive director of the institute of
5464 health care finance and policy; 1 of whom shall be appointed by the Massachusetts Hospital
5465 Association; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom
5466 shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed
5467 by the Home Care Alliance of Massachusetts; 1 of whom shall be appointed by the
5468 Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the
5469 Massachusetts Association for Behavioral Healthcare; and 2 of whom shall be appointed by the
5470 governor, 1 of whom shall be represent managed care organizations contracting with MassHealth
5471 and 1 of whom shall be an expert in medical payment methodologies from a foundation or
5472 academic institution.

5473 The commission shall examine whether public payer rates and rate methodologies
5474 provide fair compensation for health care services and promote high-quality, safe, effective,
5475 timely, efficient, culturally competent and patient-centered care. The commission's analysis
5476 shall include, but not be limited to, an examination of MassHealth rates and rate methodologies;
5477 current and projected federal financing, including Medicare rates; cost-shifting and the interplay

5478 between public payer reimbursement rates and health insurance premiums; and the degree to
5479 which public payer rates reflect the actual cost of care.

5480 To conduct its review and analysis, the commission may contract with an outside
5481 organization with expertise in the analysis of health care financing. The institute of health care
5482 finance and policy and the office of Medicaid shall provide the outside organization, to the extent
5483 possible, with any relevant data necessary for the evaluation; provided, however, that such data
5484 shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of
5485 chapter 4 of the General Laws.

5486 The commission shall file the results of its study, together with drafts of legislation, if
5487 any, necessary to carry out its recommendations, by filing the same with the clerks of the house
5488 of representatives and the senate who shall forward a copy of the study to the house and senate
5489 committees on ways and means and the joint committee on health care financing not later than
5490 April 1, 2013.

5491 SECTION 189A. There shall be a special commission to examine the economic, social
5492 and educational value of graduate medical education in the commonwealth and to recommend a
5493 fair and sustainable model for the future funding of graduate medical education in the
5494 commonwealth.

5495 The commission shall consist of 13 members: 1 of whom shall be the secretary of health
5496 and human services or a designee, who shall serve as chair; 1 of whom shall be the secretary of
5497 administration and finance or a designee; 1 of whom shall be the secretary of labor and
5498 workforce development or a designee; 1 of whom shall be the commissioner of public health or a
5499 designee; 1 of whom shall be a representative of the Massachusetts Hospital Association; 1 of

5500 whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a
5501 representative of the Massachusetts League of Community Health Centers; 4 of whom shall
5502 represent each of the commonwealth's 4 medical schools; 1 of whom shall be a representative of
5503 the Conference of Boston Teaching Hospitals; and 1 of whom shall be a resident in training at a
5504 Massachusetts hospital, appointed by the secretary of health and human services.

5505 The commission shall investigate and report on the following issues:

5506 (1) the role of residents and medical faculty in the provision of health care in the
5507 commonwealth and throughout the United States;

5508 (2) the relationship of graduate medical education to the state's physician workforce and
5509 emerging models of delivery of care;

5510 (3) the current availability and adequacy of all sources of revenue to support graduate
5511 medical education and potential additional or alternate sources of funding for graduate medical
5512 education. Such review shall include the availability of federal graduate medical education
5513 funding to different types of institutes where training takes place; and

5514 (4) approaches taken by other states to fund graduate medical education through
5515 Medicaid programs, including, but not limited to: (a) the establishment of medical education
5516 trust funds, and (b) efforts to link payments to state policy goals, including:

5517 (i) increasing the number of high demand specialties or fellowships;

5518 (ii) enhancing retention of physicians practicing in the commonwealth;

5519 (iii) promoting practice in medically underserved areas of the state and reducing
5520 disparities in health care;

- 5521 (iv) increasing the primary care workforce;
- 5522 (v) increasing the behavioral health care workforce; and
- 5523 (vi) increasing racial and ethnic diversity within the physician workforce.

5524 The commission shall file a report of its findings and recommendations, together with
5525 drafts of legislation, if any, necessary to carry out its recommendations by filing the same with
5526 the clerks of the house of representatives and the senate who shall forward a copy of the report to
5527 the house and senate committees on ways and means and the joint committee on health care
5528 financing not later than April 1, 2013.

5529 SECTION 190. There shall be a special commission to review variation in prices among
5530 providers. The commission shall consist of 22 members: 1 of whom shall be the executive
5531 director of the institute of health care finance and policy or a designee, who shall serve as chair;
5532 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be
5533 the executive director of the group insurance commission or a designee; 1 of whom shall be the
5534 secretary of health and human services or a designee; 1 of whom shall be the attorney general or
5535 a designee; 8 of whom shall be appointed by the governor, 1 of whom shall be a health
5536 economist, 1 of whom shall have expertise in the area of health care payment methodology, 1 of
5537 whom shall represent non-physician health care providers, 1 of whom shall represent an
5538 academic medical center or teaching hospital, 1 of whom shall represent a high Medicaid and
5539 low-income public payer disproportionate share hospital, 1 of whom shall represent a hospital
5540 with 200 beds or less, 1 of whom shall be a nurse practitioner; 1 of whom shall represent
5541 frontline nurses, and 1 of whom shall represent pharmaceutical manufacturers; 1 of whom shall
5542 be appointed by the senate president and shall be a health economist or have expertise in the area

5543 of health care payment methodology; 1 of whom shall be appointed by the speaker of the house
5544 of representatives and shall be a health economist or have expertise in the area of health care
5545 payment methodology; 1 of whom shall be a representative of the Massachusetts Association of
5546 Health Plans, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of
5547 Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Hospital
5548 Association, Inc.; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of
5549 whom shall be a representative of the Massachusetts Medical Device Industry Council; and 1 of
5550 whom shall be a representative of the Conference of Boston Teaching Hospitals.

5551 The commission shall conduct a rigorous analysis to identify the acceptable and
5552 unacceptable factors contributing to price variation in physician, hospitals, diagnostic testing and
5553 ancillary services. The analysis shall include, but not be limited to, an examination of the
5554 following factors: quality, medical education, stand-by service capacity, emergency service
5555 capacity, special services provided by disproportionate share hospitals and other providers
5556 serving underserved or unique populations, market share of individual providers and affiliated
5557 providers, provider size, advertising, location, research, costs, care coordination, community-
5558 based services provided by allied health professionals and use of and continued advancement of
5559 medical technology and pharmacology. The analysis shall also include a comparison of price
5560 variation between providers in the commonwealth and providers in other states.

5561 After identifying such factors, the commission shall recommend steps to reduce provider
5562 price variation and shall recommend the maximum reasonable adjustment to a commercial
5563 insurer's median rate for individual or groupings of services for each acceptable factor.

5564 To conduct its review and analysis, the commission may contract with an outside
5565 organization with expertise in the analysis of health care financing and provider payment
5566 methodologies. The institute of health care finance and policy shall provide the commission and
5567 any contracted outside organization, to the extent possible, relevant data necessary for the
5568 evaluation; provided, however, that such data shall be confidential and shall not be a public
5569 record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

5570 The commission shall file the results of its study, together with drafts of legislation, if
5571 any, necessary to carry out its recommendations, by filing the same with the clerks of the house
5572 of representatives and the senate who shall forward a copy of the study to the house and senate
5573 committees on ways and means and the joint committee on health care financing not later than
5574 January 1, 2014.

5575 SECTION 190A. There shall be a special commission to examine: (1) the feasibility of
5576 implementing required co-pays for MassHealth services, the proceeds of which shall be
5577 deposited into a trust fund to restore MassHealth adult dental benefits; and (2) methods to
5578 encourage health care providers to accept patients covered by MassHealth on a limited basis. The
5579 commission shall consist of 9 members: 1 of whom shall be the secretary of health and human
5580 services or a designee, who shall serve as chair; 1 of whom shall be the director of the office of
5581 Medicaid; 1 of whom shall be the executive director of the institute of health care finance and
5582 policy; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom shall be
5583 appointed by the Massachusetts Dental Society; 1 of whom shall be appointed by the
5584 Massachusetts Senior Care Association; 1 of whom shall be appointed by the Massachusetts
5585 League of Community Health Centers; 1 of whom shall be the executive director of Health Care

5586 For All, Inc.; and 2 of whom shall be appointed by the governor, 1 of whom shall represent
5587 managed care organizations contracting with MassHealth.

5588 The commission shall file the results of its study, together with drafts of legislation, if
5589 any, necessary to carry out its recommendations, by filing the same with the clerks of the house
5590 of representatives and the senate who shall forward a copy of the study to the house and senate
5591 committees on ways and means and the joint committee on health care financing not later than
5592 October 1, 2013.

5593 SECTION 191. (a) There shall be an e-Health commission which shall evaluate the
5594 effectiveness of expenditures authorized under section 6D of chapter 40J of the General Laws.
5595 The commission shall consist of 17 members: 1 of whom shall be the secretary of administration
5596 and finance or a designee, who shall serve as chair; 1 of whom shall be the secretary of health
5597 and human services or a designee; 1 of whom shall be the executive director of the institute of
5598 health care finance and policy or a designee; 1 of whom shall be the secretary of housing and
5599 economic development or a designee; 13 of whom shall be appointed by the governor, 1 of
5600 whom shall be an expert in health information technology, 1 of whom shall be an expert in state
5601 and federal health privacy laws, 1 of whom shall be an expert in health policy, 1 of whom shall
5602 be an expert in health information technology relative to privacy and security, 1 of whom shall
5603 be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom
5604 shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of
5605 whom shall be from a physician group practice, 1 of whom shall be a front-line registered nurse,
5606 1 of whom shall be from a Medicare-certified home health agency, and 2 of whom shall
5607 represent health insurance carriers.

5608 (b) The commission shall review the Massachusetts e-Health Institute, including an
5609 analysis of all relevant data so as to determine the effectiveness and return on investment of
5610 funding under said section 6D of said chapter 40J. The commission's review shall include
5611 specific findings and legislative recommendations including the following:-

5612 (1) to what extent the program increased the adoption of interoperable electronic
5613 health records, including to what extent the program increased the adoption of interoperable
5614 electronic health records for providers;

5615 (2) to what extent the program reduced health care costs or the growth in health
5616 care cost trends on a provider-based net cost and health plan based premium basis, including an
5617 analysis of what entities benefitted from, or were disadvantaged by, any cost reductions and the
5618 specific impact of the funding mechanism as established in subsection (a) of section 70 of
5619 chapter 118E;

5620 (3) to what extent the program increased the number of health care providers in
5621 achieving and maintaining compliance with the standards for meaningful use, beyond stage 1,
5622 established by the United States Department of Health and Human Services;

5623 (4) to what extent the program should be discontinued, amended or expanded, and
5624 if so, a timetable for implementation of the recommendations; and

5625 (5) to what extent additional public funding is needed for the e-Health Institute
5626 Fund, as established in section 6E of chapter 40J of the General Laws.

5627 (c) To conduct these studies, the commission shall contract with an outside organization
5628 with expertise in the analysis of the health care financing. In conducting its examination, the

5629 outside organization shall, to the extent possible, obtain and use actual health plan data from the
5630 all-payer claims database as administered by the institute of health care finance and policy; but
5631 such data shall be confidential and shall not be a public record for any purpose.

5632 (d) The commission shall report the results of its review and its recommendations, if any,
5633 together with drafts of legislation necessary to carry out such recommendations by March 31,
5634 2017. The report shall be provided to the chairs of the house and senate committees on ways and
5635 means and the chairs of the joint committee on health care financing and shall be posted on the
5636 department's website.

5637 SECTION 192. (a) There shall be a commission on prevention and wellness which shall
5638 evaluate the effectiveness of the program authorized under section 2G of chapter 111 of the
5639 General Laws. The commission shall consist of 20 members: 1 of whom shall be the
5640 commissioner of public health or a designee, who shall serve as the chair; 1 of whom shall be the
5641 executive director of the institute of health care finance and policy established in chapter 12C or
5642 a designee; 1 of whom shall be the secretary of health and human services or a designee; 2 of
5643 whom shall be the house and senate chairs of the joint committee on public health; 2 of whom
5644 shall be the house and senate chairs of the joint committee on health care financing; and 12 of
5645 whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field
5646 of public health economics, 1 of whom shall be a person with expertise in public health research,
5647 1 of whom shall be a person with expertise in the field of health equity, 1 of whom shall be a
5648 person from a local board of health for a city or town with a population greater than 50,000, 1 of
5649 whom shall be a person of a board of health for a city or town with a population less than 50,000,
5650 2 of whom shall be representatives of health insurance carriers, 1 of whom shall be a person from
5651 a consumer health organization, 1 of whom shall be a person from a hospital association, 1 of

5652 whom shall be a person from a statewide public health organization, 1 of whom shall be a
5653 representative of the interest of businesses, 1 of whom shall be a person representing frontline
5654 registered nurses and 1 of whom shall be a person from an association representing community
5655 health workers.

5656 (b) The commission shall review the program authorized under said section 2G of said
5657 chapter 111 and shall issue a report. The report shall include an analysis of all relevant data to
5658 determine the effectiveness and return on investment of the program including, but not limited
5659 to, an analysis of: (i) the extent to which the program impacted the prevalence of preventable
5660 health conditions; (ii) the extent to which the program reduced health care costs or the growth in
5661 health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the
5662 reduction; (iv) the extent to which workplace-based wellness or health management programs
5663 were expanded, and whether those programs improved employee health, productivity and
5664 recidivism; (v) if employee health and productivity was improved or employee recidivism was
5665 reduced, the estimated statewide financial benefit to employers; (vi) recommendations for
5666 whether the program should be discontinued, amended or expanded, as well as a timetable for
5667 implementation of the recommendations; and (vii) recommendations for whether the funding
5668 mechanism for the Prevention and Wellness Trust Fund, as established under section 68 of
5669 chapter 118E of the General Laws, should be extended beyond 2017, or whether an alternative
5670 funding mechanism should be established

5671 (c) To conduct its evaluation, the commission shall contract with an outside organization
5672 with expertise in the analysis of health care financing. In conducting its evaluation, the outside
5673 organization shall, to the extent possible, obtain and use actual health plan data from the all-
5674 payer claims database as administered by the institute of health care finance and policy;

5675 provided, however, that such data shall be confidential and shall not be a public record under
5676 clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

5677 (d) The commission shall report the results of its investigation and study and its
5678 recommendation, if any, together with drafts of legislation necessary to carry out such
5679 recommendation to the house and senate committees on ways and means, the joint committee on
5680 public health and shall be posted on the department's website not later than March 31, 2017.

5681 SECTION 192A. (a) There shall be a pharmaceutical cost containment commission
5682 established to study methods to reduce the cost of prescription drugs for both public and private
5683 payers. The commission shall consist of 16 members: 1 of whom shall be the senate chair of the
5684 joint committee on health care financing; 1 of whom shall be the house chair of the joint
5685 committee on health care financing; 1 of whom shall be the executive director of the group
5686 insurance commission or a designee; 1 of whom shall be the director of the division of insurance
5687 or a designee; 1 of whom shall be the director of the state office of pharmacy services or a
5688 designee; 1 of whom shall be the secretary of elder affairs or a designee; 1 of whom shall be the
5689 director of the Massachusetts medicaid program or a designee; 3 of whom shall be appointed by
5690 senate, 1 of whom shall be appointed by the minority leader; 3 of whom shall be appointed by
5691 the house of representatives, 1 of whom shall be appointed by the minority leader; 1 of whom
5692 shall be a representative of the Massachusetts Association of Health Plans; 1 of whom shall be a
5693 representative of the Massachusetts Hospital Association; and 1 of whom shall be a
5694 representative of Health Care For All. (b) The commission shall examine and report on the
5695 following: (i) the ability of the commonwealth to enter into bulk purchasing agreements,
5696 including agreements that would require the secretary of elder affairs, the executive director of
5697 the group insurance commission, the director of the state office of pharmacy services, the

5698 commissioners of the departments of public health, mental health and mental retardation, and
5699 any other state agencies involved in the purchase or distribution of prescription pharmaceuticals,
5700 to renegotiate current contracts; (ii) aggregate purchasing methodologies designed to lower
5701 prescription pharmaceutical costs for state and non-state providers; (iii) the ability of the
5702 commonwealth to operate as a single payer prescription pharmaceutical provider; and (iv) the
5703 feasibility of creating a program to provide all citizens access to prescription pharmaceuticals at
5704 prices negotiated by the commonwealth.

5705 (c) The commission shall report the results of its findings, together with any
5706 recommendations for legislation, programs and funding by filing the same with the clerks of the
5707 house of representatives and the senate who shall forward copies of the report to the house and
5708 senate committees on ways and means and the joint committee on health care financing not later
5709 than 12 months after the effective date of this act.

5710 SECTION 193. (a) Notwithstanding any general or special law to the contrary, this
5711 section shall facilitate the orderly transfer of employees, proceedings, rules and regulations,
5712 property and legal obligations of the following functions of state government from the transferor
5713 agency to the transferee agency, defined as follows:

5714 (1) the functions of the division of health care finance and policy, as the transferor
5715 agency, to the institute of health care finance and policy, as the transferee agency; provided
5716 however, that this section shall not apply to the functions of the division of health care finance
5717 and policy that relate to the administration of the health safety net fund;

5718 (2) the functions of the division of health care finance and policy related to the
5719 administration of the health safety net fund, as the transferor agency, to the office of Medicaid,
5720 as the transferee agency;

5721 (3) the functions of the health care quality and cost council, as the transferor
5722 agency, to the institute of health care finance and policy, as the transferee agency.

5723 (b) To the extent that employees of the transferor agency, including those who were
5724 appointed immediately before the effective date of this act and who hold permanent appointment
5725 in positions classified under chapter 31 of the General Laws or have tenure in their positions as
5726 provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold
5727 confidential positions, are transferred to the respective transferee agency, such transfers shall be
5728 effected without interruption of service within the meaning of said section 9A of said chapter 31,
5729 without impairment of seniority, retirement or other rights of the employee, and without
5730 reduction in compensation or salary grade, notwithstanding any change in title or duties resulting
5731 from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and
5732 benefits, and without change in union representation or certified collective bargaining unit as
5733 certified by the state division of labor relations or in local union representation or affiliation. Any
5734 collective bargaining agreement in effect immediately before the transfer date shall continue in
5735 effect and the terms and conditions of employment therein shall continue as if the employees had
5736 not been so transferred. The reorganization shall not impair the civil service status of any such
5737 reassigned employee who immediately before the effective date of this act either holds a
5738 permanent appointment in a position classified under chapter 31 of the General Laws or has
5739 tenure in a position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding
5740 any other general or special law to the contrary, all such employees shall continue to retain their

5741 right to collectively bargain pursuant to chapter 150E of the General Laws and shall be
5742 considered employees for the purposes of said chapter 150E. Nothing in this section shall be
5743 construed to confer upon any employee any right not held immediately before the date of said
5744 transfer, or to prohibit any reduction of salary grade, transfer, reassignment, suspension,
5745 discharge, layoff, or abolition of position not prohibited before such date.

5746 (c) All petitions, requests, investigations and other proceedings appropriately and duly
5747 brought before the transferor agency or duly begun by the transferor agency and pending before
5748 it before the effective date of this act, shall continue unabated and remain in force, but shall be
5749 assumed and completed by the transferee agency.

5750 (d) All orders, rules and regulations duly made and all approvals duly granted by the
5751 transferor agency, which are in force immediately before the effective date of this act, shall
5752 continue in force and shall thereafter be enforced, until superseded, revised, rescinded or
5753 canceled, in accordance with law, by the transferee agency.

5754 (e) All books, papers, records, documents, equipment, buildings, facilities, cash and other
5755 property, both personal and real, including all such property held in trust, which immediately
5756 before the effective date of this act are in the custody of the transferor agency shall be transferred
5757 to the transferee agency.

5758 (f) All duly existing contracts, leases and obligations of the transferor agency shall
5759 continue in effect but shall be assumed by the transferee agency. No existing right or remedy of
5760 any character shall be lost, impaired or affected by this act.

5761 SECTION 193A. Notwithstanding any general or special law to the contrary, the office
5762 of Medicaid and the department of unemployment assistance shall, in consultation with the

5763 executive office of health and human services, develop and implement a means by which the
5764 office of Medicaid may access information as to the status of or termination of unemployment
5765 benefits and the associated insurance coverage by the medical security plan, as administered by
5766 the executive office of labor and workforce development, for the purposes of determining
5767 eligibility for those individuals applying for benefits through health care insurance programs
5768 administered by the executive office of health and human services. The office and the
5769 department shall implement this system not later than 3 months following the passage of this act;
5770 provided, however, that if legislative action is required prior to implementation,
5771 recommendations for such action shall be filed with the clerks of the house of representatives
5772 and the senate and the joint committee on health care financing not later than 2 months following
5773 the passage of this act.

5774 SECTION 194. Notwithstanding any general or special law to the contrary, the
5775 commissioner of health care finance and policy as of the effective date of this act shall, with the
5776 approval of the governor, become the interim executive director of the institute of health care
5777 finance and policy on the effective date of this act. The interim executive director shall serve at
5778 the pleasure of the governor, and may be removed by the governor at any time. If there is a
5779 vacancy in the office of the interim executive director before January 1, 2014, the executive
5780 director of the institute of health care finance and policy shall be appointed by a majority vote of
5781 the governor, the auditor and the attorney general as required under section 2 of chapter 12C of
5782 the General Laws.

5783 Beginning on January 1, 2014, the executive director of the institute of health care
5784 finance and policy shall be appointed by a majority vote of the governor, the auditor and the
5785 attorney general as required under section 2 of chapter 12C of the General Laws.

5786 SECTION 195. Notwithstanding any general or special law or rule or regulation to the
5787 contrary, all orders, rules and regulations duly made and all approvals duly granted by the
5788 transferor agency, the division of health care finance and policy, in relation to sections 2A, 6B, 7,
5789 9 to 15, 17, 25 and 28 to 39 of chapter 118G of the General Laws, which are in force
5790 immediately before the effective date of this act, shall continue in force and shall thereafter be
5791 enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the
5792 transferee agency, the executive office of health and human services.

5793 SECTION 196. Notwithstanding any general or special law or rule or regulation to the
5794 contrary, all orders, rules and regulations duly made and all approvals duly granted by the
5795 transferor agency, the division of health care finance and policy, in relation to section 18 of
5796 chapter 15A, sections 6C and 18B of chapter 118G and section 188 of chapter 149 of the General
5797 Laws, which are in force immediately before the effective date of this act, shall continue in force
5798 and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance
5799 with law, by the transferee agency, the commonwealth health insurance connector.

5800 SECTION 197. Notwithstanding any general or special law or rule or regulation to the
5801 contrary, all orders, rules and regulations duly made and all approvals duly granted by the
5802 transferor agency, the division of health care finance and policy, in relation to sections 5, 6, 6A,
5803 6½, 8, 16 and 23 of chapter 118G of the General Laws, which are in force immediately before
5804 the effective date of this act, shall continue in force and shall thereafter be enforced, until
5805 superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency, the
5806 institute of health care finance and policy.

5807 SECTION 198. Notwithstanding any general or special law or rule or regulation to the
5808 contrary, all orders, rules and regulations duly made and all approvals duly granted by the
5809 transferor agency, the division of health care finance and policy, in relation to section 41 chapter
5810 118G of the General Laws, which are in force immediately before the effective date of this act,
5811 shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or
5812 canceled, in accordance with law, by the transferee agency, the department of public health.

5813 SECTION 198A. The executive office of health and human services shall seek from the
5814 secretary of the U.S. Department of Health and Human Services an exemption or waiver from
5815 the Medicare requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing
5816 facility be preceded by a 3-day hospital stay.

5817 SECTION 198B. The secretary of administration and finance and the secretary of health
5818 and human services shall evaluate the feasibility of contracting for recycling durable medical
5819 equipment purchased and issued by the commonwealth through any and all of its medical
5820 assistance programs.

5821 Said evaluation shall include but not be limited to a request for qualifications or proposals
5822 for entities capable of developing, implementing and operating a system of recycling whereby an
5823 inventory of such equipment is developed and managed so as to maximize the quality of service
5824 delivery to equipment recipients and to minimize costs and losses attributable to waste, fraud or
5825 abuse.

5826 The secretary of administration and finance shall report to the joint committee on health
5827 care financing, the house committee on ways and means and the senate committee on ways and
5828 means the findings of said evaluation, together with cost estimates for the operation of a

5829 recycling program, estimates of the savings it would generate and legislative recommendations,
5830 not later than October 31, 2012.

5831 SECTION 198C. The institute of health care finance and policy shall conduct a
5832 comprehensive study to investigate barriers to individuals seeking to change health insurance
5833 plans, either upon a qualifying status change or during an open-enrollment period. The study
5834 shall include, but not be limited to, the identification and review of such barriers, such as the
5835 impact of a change in insurance plans on consumers who have used some or all of their yearly
5836 plan deductibles, as well as recommendations for alleviating any barriers. The institute shall file
5837 a report of its study, including recommendations and drafts of any legislation, if necessary, with
5838 the clerks of the senate and house of representatives within 1 year of the effective date of this act.

5839 SECTION 198D. Subsection (c) of section 25A of chapter 111 of the General Laws and
5840 clause (2) of subsection (g) of section 25C of said chapter 111 shall not apply to the review of
5841 an application for a determination of need that is filed with the department of public health under
5842 said chapter 111 until (i) October 1, 2013 or (ii) the date on which the department of public
5843 health submits for the first time a health resource plan under said section 25A of said chapter
5844 111, whichever occurs first.

5845 SECTION 198E. The office of Medicaid shall, within 6 months of the passage of this
5846 act, take any and all necessary actions to ensure that social security numbers are required on all
5847 medical benefits request forms to the extent permitted by federal law and that social security
5848 numbers are provided by all applicants who possess them.

5849 If for any reason the office of Medicaid determines that it is or will be unable to
5850 accomplish the foregoing within 6 months of the effective date of this act, the office shall submit

5851 a detailed report of the reasons for such inability to the clerks of the house of representatives and
5852 the senate within 6 months following the effective date of this act.

5853 SECTION 198F. The institute of health care finance and policy shall, within 6 months of
5854 the effective date of this act, ensure (i) that the identity, age, residence and eligibility of all
5855 applicants are verified before payments, other than emergency bad debt payments, are made by
5856 the Health Safety Net Trust Fund; and (ii) that the health safety net is the payor of last resort by
5857 performing third party liability investigations on health safety net claims and by implementing
5858 other such programs as needed.

5859 If for any reason the institute determines that it is or will be unable to accomplish the
5860 foregoing within 6 months of the effective date of this act, the institute shall submit a detailed
5861 report of the reasons for such inability to the clerks of the house of representatives and the senate
5862 within 6 months of the effective date of this act.

5863 SECTION 199. The division of insurance shall develop prior authorization forms under
5864 section 24 of chapter 176O of the General Laws not later than July 1, 2013.

5865 SECTION 199A. All appointments under section 192A shall be made within 60 days of
5866 the effective date of this act.

5867 SECTION 199B. Section 271 of chapter 127 of the acts of 1999, as amended in sections
5868 170A and 170B, and section 62 of chapter 177 of the acts of 2001, as amended in section 170C,
5869 shall be fully implemented by January 1, 2013.

5870 SECTION 200. Section 87 shall take effect on January 1, 2015.

5871 SECTION 201. Section 70 of chapter 118E of the General Laws shall take effect on July
5872 1, 2012.

5873 SECTION 202. Section 70 of chapter 118E of the General Laws is hereby repealed.

5874 SECTION 202A. The requirements of section 47BB of chapter 175 of the General Laws
5875 shall apply to all policies, contracts and certificates executed, delivered, issued for delivery,
5876 continued or renewed on or after January 1, 2013. For purposes of said section 47BB, all
5877 contracts shall be considered to be renewed not later than the next yearly anniversary of the
5878 contract date.

5879 SECTION 202B. Section 114A shall take effect on February 1, 2013.

5880 SECTION 203. Sections 144 and 147 shall take effect on July 1, 2013.

5881 SECTION 204. Sections 191 and 192 shall take effect on July 1, 2016.

5882 SECTION 205. Section 202 shall take effect on July 1, 2017.