

HOUSE No. 3235

The Commonwealth of Massachusetts

PRESENTED BY:

Michael J. Finn

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act ensuring safe and equitable ambulatory care.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Michael J. Finn</i>	<i>6th Hampden</i>	<i>1/20/2017</i>
<i>Gerard Cassidy</i>	<i>9th Plymouth</i>	<i>1/20/2017</i>

HOUSE No. 3235

By Mr. Finn of West Springfield, a petition (accompanied by bill, House, No. 3235) of Michael J. Finn and Gerard Cassidy relative to the health care delivery and payment system and ensuring safe and equitable ambulatory care. Public Health.

The Commonwealth of Massachusetts

**In the One Hundred and Ninetieth General Court
(2017-2018)**

An Act ensuring safe and equitable ambulatory care.

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. Chapter 6D of the General Laws, is hereby amended by striking out section
2 5, as appearing in the 2014 Official Edition, and inserting in place thereof the following section:-

3 The commission shall monitor the reform of the health care delivery and payment system
4 in the commonwealth under this chapter. The commission shall: (i) set health care cost growth
5 goals for the commonwealth; (ii) enhance the transparency of provider organizations and clinics
6 as defined by section 52 of chapter 111 of the General Laws; (iii) monitor the development of
7 ACOs and patient-centered medical homes; (iv) monitor the adoption of alternative payment
8 methodologies; (v) foster innovative health care delivery and payment models that lower health
9 care cost growth while improving the quality of patient care; (vi) monitor and review the impact
10 of changes within the health care marketplace and (vii) protect patient access to necessary health
11 care services.

12

13 SECTION 2. Section 8 of said chapter 6D, as so appearing, is hereby amended by
14 striking out paragraphs (d) and (e) and inserting in place thereof the following paragraphs:-

15
16 (d) The commission shall identify as witnesses for the public hearing a representative
17 sample of providers, provider organizations, payers and others, including: (i) at least 3 academic
18 medical centers, including the 2 acute hospitals with the highest level of net patient service
19 revenue; (ii) at least 3 disproportionate share hospitals, including the 2 hospitals whose largest
20 per cent of gross patient service revenue is attributable to Title XVIII and XIX of the federal
21 Social Security Act or other governmental payers; (iii) community hospitals from at least 3
22 separate regions of the commonwealth; (iv) freestanding ambulatory surgical centers from at
23 least 3 separate regions of the commonwealth; (v) at least 1 urgent care clinic as defined in
24 section 52 of chapter 111 of the General Laws; (vi) at least 1 limited services clinic as defined in
25 section 52 of chapter 111 of the General Laws; (vii) community health centers from at least 3
26 separate regions of the commonwealth; (viii) the 5 private health care payers with the highest
27 enrollments in the commonwealth; (ix) any managed care organization that provides health
28 benefits under Title XIX; (x) the group insurance commission; (xi) at least 3 municipalities that
29 have adopted chapter 32B; (xii) at least 4 provider organizations, at least 2 of which shall be
30 certified as accountable care organizations, 1 of which has been certified as a model ACO, which
31 shall be from diverse geographic regions of the commonwealth; and (xii) any witness identified
32 by the attorney general or the center.

33

34 (e) Witnesses shall provide testimony under oath and subject to examination and cross
35 examination by the commission, the executive director of the center and the attorney general at
36 the public hearing in a manner and form to be determined by the commission, including, but not
37 limited to: (i) in the case of providers and provider organizations; testimony concerning payment
38 systems; care delivery models; payer mix; the payer mix of ambulatory surgical centers, urgent
39 care clinics as defined in section 52 of chapter 111 of the General Laws, and limited services
40 clinics as defined in section 52 of chapter 111 of the General Laws, as compared to hospitals in
41 the same primary service area; cost structures; administrative and labor costs; capital and
42 technology cost; adequacy of public payer reimbursement levels; reserve levels; utilization
43 trends; relative price; quality improvement and care-coordination strategies; investments in
44 health information technology; the relation of private payer reimbursement levels to public payer
45 reimbursements for similar services; efforts to improve the efficiency of the delivery system;
46 efforts to reduce the inappropriate or duplicative use of technology and the impact of price
47 transparency on prices; and (ii) in the case of private and public payers, testimony concerning
48 factors underlying premium cost and rate increases, the relation of reserves to premium costs,
49 efforts by the payer to reduce the use of fee-for-service payment mechanisms, the payer's efforts
50 to develop benefit design, network design and payment policies that enhance product
51 affordability and encourage efficient use of health resources and technology including utilization
52 of alternative payment methodologies, efforts by the payer to increase consumer access to health
53 care information, efforts by the payer to promote the standardization of administrative practices,
54 the impact of price transparency on prices and any other matters as determined by the
55 commission. The commission shall solicit testimony from any payer which has been identified
56 by the center's annual report under subsection (a) of section 16 of chapter 12C as (1) paying

57 providers more than 10 per cent above or more than 10 per cent below the average relative price
58 or (2) entering into alternative payment contracts that vary by more than 10 per cent. Any payer
59 identified by the center's report shall explain the extent of price variation between the payer's
60 participating providers and describe any efforts to reduce such price variation.

61

62 SECTION 3. Subsection (a) of section 8 of chapter 12C of the General Laws, as so
63 appearing, is hereby amended by striking out the second sentence and inserting in place thereof
64 the following sentence:-

65

66 Such uniform reporting shall enable the center to identify, on a patient-centered and
67 provider-specific basis, statewide and regional trends in the cost, price, availability, utilization,
68 and public payer mix of medical, surgical, diagnostic and ancillary services provided by acute
69 hospitals, nursing homes, chronic care and rehabilitation hospitals, other specialty hospitals,
70 clinics, including mental health clinics, ambulatory surgical centers, urgent care clinics as
71 defined in section 52 of chapter 111 of the General Laws, limited services clinics as defined by
72 section 52 of chapter 111 of the General Laws, and other ambulatory care providers as the center
73 may specify.

74

75 SECTION 4. Said section 8 of chapter 12C, as so appearing, is hereby further amended
76 by inserting after paragraph (c) the following paragraph:-

77

78 (c ½) The center shall also collect and analyze such data as it considers necessary in
79 order to better protect the public's interest in monitoring the financial conditions of ambulatory
80 care providers, including ambulatory surgical centers, urgent care clinics as defined in section 52
81 of chapter 111 of the General Laws, and limited services clinics as defined by section 52 of
82 chapter 111 of the General Laws. The information shall be analyzed on an industry-wide and
83 ambulatory care provider-specific basis and shall include, but not be limited to: (1) gross and net
84 patient service revenues; (2) sources of revenue; (3) private sector charges; (4) trends in
85 outpatient case mix and payer mix, including public payer mix; (5) total payroll as a per cent of
86 operating expenses, as well as the salary and benefits of the top 3 highest compensated
87 employees, identified by position description and specialty; and (6) other relevant measures of
88 financial health or distress.

89

90 The center shall publish annual reports and establish a continuing program of
91 investigation and study of financial trends in the ambulatory care provider industry, including an
92 analysis of systemic inefficiencies and payer mix that contribute to financial distress in the acute
93 hospital industry.

94

95 SECTION 5. Paragraph (d) of section 15 of said chapter 12C, as so appearing, is hereby
96 amended by striking out the first sentence and inserting in place thereof the following sentence:-

97

98 The Lehman center shall develop and administer a patient safety and medical error
99 reduction education and research program to assist health care professionals, health care
100 facilities, urgent care clinics as defined in section 52 of chapter 111 of the General Laws, and
101 agencies and the general public regarding issues related to the causes and consequences of
102 medical error and practices and procedures to promote the highest standard for patient safety in
103 the commonwealth.

104

105 SECTION 6. Subsection (a) of section 16 of said chapter 12C, as so appearing, is hereby
106 amended by striking out the first paragraph and inserting in place thereof the following
107 paragraph:-

108

109 The center shall publish an annual report based on the information submitted under
110 sections 8, 9 and 10 concerning health care provider, provider organization and private and
111 public health care payer costs and cost trends, section 13 of chapter 6D relative to market power
112 reviews and section 15 relative to quality data. The center shall compare the costs and cost trends
113 with the health care cost growth benchmark established by the health policy commission under
114 section 9 of chapter 6D, analyzed by regions of the commonwealth, and shall detail: (1) baseline
115 information about cost, price, quality, utilization and market power in the commonwealth's
116 health care system; (2) cost growth trends for care provided within and outside of accountable
117 care organizations and patient-centered medical homes; (3) cost growth trends by provider
118 sector, including but not limited to, hospitals, hospital systems, non-acute providers, ambulatory
119 surgical centers, urgent care clinics as defined in section 52 of chapter 111 of the General Laws,

120 limited services clinics as defined in section 52 of chapter 111 of the General Laws,
121 pharmaceuticals, medical devices and durable medical equipment; provided, however, that any
122 detailed cost growth trend in the pharmaceutical sector shall consider the effect of drug rebates
123 and other price concessions in the aggregate without disclosure of any product or manufacturer-
124 specific rebate or price concession information, and without limiting or otherwise affecting the
125 confidential or proprietary nature of any rebate or price concession agreement; (4) factors that
126 contribute to cost growth within the commonwealth's health care system and to the relationship
127 between provider costs and payer premium rates; (5) the proportion of health care expenditures
128 reimbursed under fee-for-service and alternative payment methodologies; (6) the impact of
129 health care payment and delivery reform efforts on health care costs including, but not limited to,
130 the development of limited and tiered networks, increased price transparency, increased
131 utilization of electronic medical records and other health technology; (7) the impact of any
132 assessments including, but not limited to, the health system benefit surcharge collected under
133 section 68 of chapter 118E, on health insurance premiums; (8) trends in utilization of
134 unnecessary or duplicative services, with particular emphasis on imaging and other high-cost
135 services; (9) the prevalence and trends in adoption of alternative payment methodologies and
136 impact of alternative payment methodologies on overall health care spending, insurance
137 premiums and provider rates; (10) the development and status of provider organizations in the
138 commonwealth including, but not limited to, acquisitions, mergers, consolidations and any
139 evidence of excess consolidation or anti-competitive behavior by provider organizations; (11) the
140 impact of health care payment and delivery reform on the quality of care delivered in the
141 commonwealth; and (12) the impact of the public payer mix of ambulatory surgical centers,
142 urgent care clinics as defined in section 52 of chapter 111 of the General Laws, and limited

143 services clinics as defined in section 52 of chapter 111 of the General Laws on acute care
144 hospitals.

145

146 SECTION 7. Said chapter 111 is hereby amended by striking out section 51D, as so
147 appearing, and inserting in place thereof the following section:--

148

149 No acute hospital, ambulatory surgical center, urgent care clinic, or limited services clinic
150 shall impose any discriminatory restrictions or conditions relating to admission, availability of
151 services, treatment, transfer or discharge with respect to any patient because that patient is a
152 medicare beneficiary. Prohibited practices include, but are not limited to, any such
153 discrimination based on the diagnostically related group classification of such a beneficiary or
154 any other criteria, including cost of treatment, severity of illness, and average length of stay,
155 which are not equally applied to all patients with comparable medical needs seeking or receiving
156 the services of the hospital, ambulatory surgical center, urgent care clinic, or limited services
157 clinic. For medicare patients, admission and discharge shall be consistent with Public Laws 97-
158 248, 98-21 and 09-369 and any other applicable federal statutes and regulations.

159

160 The department shall establish an advocacy office for the receipt of complaints of alleged
161 violations of the provisions of this section. Said advocacy office shall investigate such alleged
162 violations and if the advocacy office finds cause for crediting the allegations of a complaint, it
163 will seek to resolve such complaint through negotiation. Hospitals, ambulatory surgical centers,

164 urgent care clinics, or limited services clinics shall cooperate with said advocacy office in the
165 investigation and resolution of an alleged violation. Such cooperation shall include, but not be
166 limited to, the provisions of nonconfidential information reasonably related to the alleged
167 violation, and the provision of patient records with the consent of the patient.

168

169 If the advocacy office cannot promptly negotiate a resolution to a complaint, the
170 department may forward the complaint and any information obtained to the attorney general. The
171 attorney general may bring a civil action for injunctive or other equitable relief to enforce the
172 provisions of this section.

173

174 If the advocacy office cannot negotiate a resolution to the complaint and has cause to
175 believe there exists a practice or pattern of violations of this section at any hospital, ambulatory
176 surgical center, urgent care clinics, or limited services clinic, the department may also forward
177 the complaints to the regional office of the health care financing administration for appropriate
178 action.

179

180 Any information supplied by a hospital, ambulatory surgical center, urgent care clinics,
181 or limited services clinic to the department which is provided to the attorney general shall not,
182 unless otherwise ordered by a court for good cause shown, be disclosed to any person other than
183 the patient, the authorized agent of the patient or representative of the attorney general, unless

184 with the consent of the hospital, ambulatory surgical center, urgent care clinics, or limited
185 services clinic providing the same.

186

187 The department shall have the authority to promulgate such regulation as may be
188 necessary to implement the provisions of this section.

189

190 The attorney general may bring a civil action for injunctive or other equitable relief to
191 enforce the provisions of this section.

192

193 In any action brought by the attorney general under this section, the court may also award
194 a civil penalty of not more than five thousand dollars for each violation unless the peer review
195 organization of said health care financing administration has formally commenced sanction
196 proceedings against an institution as provided in 42 CFR 474.30.

197

198 Hospitals, ambulatory surgical centers, urgent care clinics, and limited services clinics
199 shall provide written notice of the rights established by this section to every medicare eligible
200 person seeking services in the facility. In addition, notice of such rights shall be conspicuously
201 posted in the facility.

202

203 Each acute care hospital is hereby required, in accordance with applicable federal and
204 state regulations, to create for each medicare patient determined to need assistance with post-
205 hospital care, a written comprehensive, individualized, discharge plan consistent with medical
206 discharge orders and identified patient needs. Said plan shall be developed with the participation
207 of appropriate health care professionals, the medicare patient and, as appropriate, the patient's
208 family or representative. The patient's representative shall be selected in accordance with
209 department regulations. The discharge plan shall be given to the patient or the patient's
210 representative at least twenty-four hours prior to discharge, except where such a requirement is
211 not feasible due to a short length of stay. If said plan is revised due to the medical needs of the
212 patient or due to a space becoming available in an appropriate institutional setting, the twenty-
213 four hour requirement shall not apply to the amended plan, except insofar as such timing relates
214 to the filing of a request for review with the advocacy office as hereinafter provided.

215

216 The discharge plan shall include at least the following information:

217 (1) identification of the post-hospital services needed by the patient, including home
218 health and homemaker services, and of the post-hospital social needs of the patient, as
219 determined in accordance with procedures set forth by the department;

220 (2) the services that have been arranged for the patient;

221 (3) the names, addresses, and telephone numbers of service providers;

222 (4) the service schedule as requested by the hospital;

223 (5) medications prescribed and instructions for their use or verification that such
224 information was provided separately;

225 (6) scheduled follow-up medical appointments or verification that such information was
226 provided separately; and

227 (7) such other information as the department may require.

228

229 Each hospital shall have a clear, concise front page on the discharge plan, which front
230 page shall be written in large print and understandable language. The front page shall contain at
231 least the following:

232 (1) the name and telephone number of the hospital discharge planning coordinator to be
233 contacted in the event the patient has any problems with post-hospital services after said patient
234 leaves the hospital;

235 (2) a notice that, in the event the patient or the patient's representative does not agree with
236 the discharge plan, the discharge planning coordinator and the patient's physician shall meet with
237 the patient or the patient's representative in an effort to develop a plan that is acceptable to the
238 patient;

239 (3) a notice, including the advocacy office telephone number, that, if an acceptable
240 resolution is not reached as a result of the meeting provided for in clause (2), the patient or the
241 patient's representative may file a request for review of the discharge plan with the advocacy
242 office, as hereinafter provided;

243 (4) a notice that signing the discharge plan does not necessarily indicate approval of the
244 plan and does not preclude the right to request a meeting or a review pursuant to clauses (2) and
245 (3); and

246 (5) a signature line for the patient or the patient's representative acknowledging
247 participation in the development of the discharge plan and receipt of a copy of said plan.

248

249 If the patient or the patient's representative does not sign the plan, the reason for not
250 signing shall be noted on the plan. A signed or noted copy of the plan shall be retained in the
251 patient's medical record. The patient's medical record shall also document that said plan was
252 communicated orally to the patient or to the patient's representative.

253

254 No hospital may discharge a medicare patient without the patient or patient's
255 representative having received, read and signed the front page of the discharge plan or upon
256 decision of the advocacy office.

257

258 If a discharge plan cannot be agreed upon as a result of the meeting of the patient or the
259 patient's representative, the discharge planning coordinator and the patient's physician, as
260 provided for in this section, the patient or the patient's representative shall have the right to file a
261 request for a review of said discharge plan with the department's advocacy office. The hospital
262 also shall have the right to file a request for a review of said discharge. A request for review shall
263 be made with the advocacy office not later than noon of the first working day after the date the

264 patient or the patient's representative receives the written discharge plan. The hospital shall
265 deliver to the advocacy office the records required to review the discharge plan by the close of
266 such working day. The advocacy office shall either approve or disapprove the discharge plan
267 within one working day of receiving the request for review and the hospital records. Said
268 discharge plan shall not be approved unless the requirements set forth herein have been satisfied.

269

270 If the advocacy office approves the discharge plan, discharge shall occur pursuant to the
271 approved plan by noon of the day following notification of the advocacy office's decision, unless
272 hospital and patient agree otherwise. If the advocacy office does not approve the discharge plan,
273 said office shall state the problems needing correction, and the hospital shall not charge the
274 medicare patient for inpatient hospital services until an alternative plan is developed to resolve
275 the problems set forth by the advocacy office. The requirements of this section relating to the
276 initial discharge also shall apply to the alternative plan.

277

278 If a timely request for review has been filed with the advocacy office, the hospital shall
279 not charge the medicare patient for inpatient hospital services furnished before noon of the day
280 after said patient is notified by telephone or otherwise of the advocacy office's decision. If notice
281 is made by telephone, the notice shall be made to both parties to the review and shall be followed
282 by written notice as soon as possible.

283

284 No patient shall be discharged or transferred without a physician's order, except where
285 such patient leaves against medical advice. No patient shall be discharged until the hospital has
286 made all appropriate contacts to initiate the provisions for aftercare services.

287

288 A medicare patient treated at the emergency room of an acute care hospital or at an
289 ambulatory surgical center, urgent care clinic, or limited services clinic shall be provided with a
290 discharge plan in accordance with the requirements of this section, with the exception of the right
291 to request a review of such discharge plan by the advocacy office prior to such discharge.

292

293 Nothing in this section shall be construed to prevent a hospital, ambulatory surgical
294 center, urgent care clinic, or limited services clinic from implementing a decision relating to
295 patient care which is in the best interest of a patient and in conformity with good medical and
296 hospital practice.

297

298 Nothing in this section shall be construed as limiting any other rights or remedies
299 provided by law to medicare patients. Nothing in this section shall be construed to limit the
300 applicability of section sixty B of chapter two hundred and thirty-one. Nothing in this section
301 shall give rise to or limit an otherwise available cause of action in negligence or medical
302 malpractice.

303

304 The department shall conduct an evaluation as to whether the introduction of the
305 medicare prospective payment system has affected the delivery of quality care to medicare
306 beneficiaries including the appropriateness of admissions and discharges to acute care hospitals.
307 Said department shall submit an interim report of its findings to the clerk of the house of
308 representatives to the general court no later than March first, nineteen hundred and eighty-seven,
309 and a final report not later than March first, nineteen hundred and eighty-eight, including any
310 applicable recommendations for legislation arrived after consultation with the Massachusetts
311 Hospital Association, the Massachusetts Medical Society, and others. Acute hospitals are hereby
312 required to submit to the department relevant data reasonably necessary to conduct this
313 evaluation. The department shall not seek information directly from hospitals when such
314 information is available from other sources. The department shall protect the confidentiality of
315 patient information provided by the hospitals. No data, findings, conclusions or reports
316 developed by the department during or as a result of such evaluation from hospital/practitioner
317 data shall be released without thirty days prior notice to such hospital. Comments by the hospital
318 shall accompany the release of the data, findings, conclusions or reports.

319

320 SECTION 8. Said chapter 111 is hereby amended by striking out section 51G, as so
321 appearing, and inserting in place thereof the following section:--

322

323 (1) No original license shall be granted to establish or maintain an acute-care hospital, as
324 defined by section 25B; an ambulatory surgical center that is not otherwise owned by, a joint
325 venture with, or affiliated with an existing acute care hospital in said hospital's primary service

326 area; an urgent care clinic that is not otherwise owned by, a joint venture with, or affiliated with
327 an existing acute care hospital in said hospital's primary service area; or a limited services clinic
328 that is not otherwise owned by, a joint venture with, or affiliated with an existing acute care
329 hospital in said hospital's primary service area unless there is a determination by the department
330 of the suitability and responsibility of the prospective licensee in accordance with regulations of
331 the department.

332

333 For purposes of this section, the department's determination of suitability and
334 responsibility shall include the following factors:

335

336 (a) the financial capacity of the prospective licensee to operate the hospital, ambulatory
337 surgical center, urgent care clinic, or limited services clinic in accordance with applicable laws;

338

339 (b) the history of the prospective licensee in providing acute care, including in states
340 other than the commonwealth, if any, measured by compliance with the applicable statutes and
341 regulations governing the operation of hospitals, ambulatory surgical centers, urgent care clinic,
342 or limited services clinics in such states;

343

344 (c) the participation of persons residing in the non-profit entity's primary service area in
345 oversight of the resulting hospital, ambulatory surgical center, urgent care clinic, or limited
346 services clinic; and

347

348 (d) whether the transaction will create a significant effect on the availability or
349 accessibility of health care services to the affected communities.

350

351 (2) No original license shall be granted to establish or maintain an acute care hospital as
352 defined in section 25B; ambulatory surgical center that is not otherwise owned by, a joint venture
353 with, or affiliated with an existing acute care hospital in said hospital's primary service area; an
354 urgent care clinic that is not otherwise owned by, a joint venture with, or affiliated with an
355 existing acute care hospital in said hospital's primary service area; or limited services clinic that
356 is not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital
357 in said hospital's primary service area unless all financial transactions, including remuneration of
358 all officers of hospitals, ambulatory surgical centers, urgent care clinics, or limited services
359 clinics affected by the transaction, are disclosed as part of the licensure process, and unless a
360 public hearing is held, according to procedures established in regulation by the department, prior
361 to the granting of the license.

362

363 (3) No original license shall be granted to establish or maintain an acute-care hospital, as
364 defined by section 25B, any subsequent successor or acquirer, or to any ambulatory surgical
365 center that is not otherwise owned by, a joint venture with, or affiliated with an existing acute
366 care hospital in said hospital's primary service area; urgent care clinic that is not otherwise
367 owned by, a joint venture with, or affiliated with an existing acute care hospital in said hospital's
368 primary service area; or limited services clinic that is not otherwise owned by, a joint venture

369 with, or affiliated with an existing acute care hospital in said hospital's primary service area
370 unless the applicant agrees to maintain or increase the percentage of gross patient service
371 revenues allocated to free care. The department may permit the applicant to reduce said
372 percentage if the department determines that demographic or other changes in the hospital's,
373 ambulatory surgical center's, urgent care clinic's, or limited services clinic's service area justify
374 a reduction in said percentage. The department shall promulgate regulations to enforce this
375 paragraph and any agreement made by an applicant concerning free care.

376

377 (4) Any hospital shall inform the department 90 days prior to the closing of the hospital,
378 ambulatory surgical center, urgent care clinic, or limited services clinic or the discontinuance of
379 any essential health service provided therein. The department shall by regulation define
380 "essential health service" for the purposes of this section. The department shall, in the event that
381 a hospital, ambulatory surgical center, urgent care clinic, or limited services clinic proposes to
382 discontinue an essential health service or services, conduct a public hearing on the closure of said
383 essential services or of the hospital, ambulatory surgical center, urgent care clinic, or limited
384 services clinic. The department shall determine whether any such discontinued services are
385 necessary for preserving access and health status in the hospital's, ambulatory surgical center's,
386 urgent care clinic's, or limited services clinic's service area and shall require hospitals,
387 ambulatory surgical centers, urgent care clinics, or limited services clinics to submit a plan for
388 assuring access to such necessary services following the hospital's, ambulatory surgical center's,
389 urgent care clinic's, or limited services clinic's closure of the service, and assure continuing
390 access to such services in the event that the department determines that their closure will
391 significantly reduce access to necessary services. The department shall conduct a public hearing

392 prior to a determination on the closure of said essential services or of the hospital, ambulatory
393 surgical center, urgent care clinic, or limited services clinic. No original license shall be granted
394 to establish or maintain an acute-care hospital, ambulatory surgical center, urgent care clinic, or
395 limited services clinic as defined by section 25B, unless the applicant submits a plan, to be
396 approved by the department, for the provision of community benefits, including the identification
397 and provision of essential health services. In approving the plan, the department may take into
398 account the applicant's existing commitment to primary and preventive health care services and
399 community contributions as well as the primary and preventive health care services and
400 community contributions of the predecessor hospital, ambulatory surgical center, urgent care
401 clinic, or limited services clinic. The department may waive this requirement, in whole or in part,
402 at the request of the applicant which has provided or at the time the application is filed, is
403 providing, substantial primary and preventive health care services and community contributions
404 in its service area.

405

406 (5) No original license shall be granted to establish or maintain an acute care hospital;
407 ambulatory surgical center that is not otherwise owned by, a joint venture with, or affiliated with
408 an existing acute care hospital in said hospital's primary service area; urgent care clinic that is
409 not otherwise owned by, a joint venture with, or affiliated with an existing acute care hospital in
410 said hospital's primary service area; or limited services clinic that is not otherwise owned by, a
411 joint venture with, or affiliated with an existing acute care hospital in said hospital's primary
412 service area as defined by section 25B which results from the merger or acquisition of the
413 hospital, ambulatory surgical center, urgent care clinic, or limited services clinic, unless the
414 board of trustees of the hospital, ambulatory surgical center, urgent care clinic, or limited

415 services clinic publicly presents and evaluates all proposals for such a merger or acquisition
416 according to rules and regulations promulgated by the department.

417

418 (6) Whenever the department finds upon inspection, or through information in its
419 possession, that a licensee is not in compliance with a requirement established under this section,
420 the department may order the licensee to correct such deficiency. Every such correction order
421 shall include a statement of the deficiencies found, the period prescribed within which the
422 deficiency must be corrected, and the provisions of law relied upon. The department may assess
423 the licensee ordered to correct deficiencies no less than \$1,000 and not more than \$10,000 per
424 deficiency for each day the deficiency continues to exist beyond the date prescribed for
425 correction. Within seven days of receipt, the affected licensee may file a written request with the
426 department for administrative reconsideration of the order or any portion thereof.

427

428 SECTION 9. Section 51H of said chapter 11, as so appearing, is hereby amended by
429 striking the definition of “facility” and replacing it with the following definition:-

430

431 "Facility", a hospital, institution for the care of unwed mothers, clinic providing
432 ambulatory surgery as defined by section 25B, urgent care clinic as defined by section 52, or a
433 limited services clinic as defined by section 52.

434

435 SECTION 10. Section 51I of said chapter 11, as so appearing, is hereby amended by
436 striking the definition of “facility” and replacing it with the following definition:-

437

438 "Facility," a hospital, an institution maintaining an Intensive Care Unit, an institution
439 providing surgical services, clinic providing ambulatory surgery, urgent care clinic as defined by
440 section 52, or a limited services clinic as defined by section 52.

441

442 SECTION 11. The definition of “Clinic” in section 52 of said chapter 111, as so
443 appearing, is hereby amended by inserting after the word “rehabilitation,” in both instances in
444 which it appears, the following words:-

445

446 urgent care, limited services,

447

448 SECTION 12. Said section 52, as so appearing, is hereby further amended by adding the
449 following two definitions:-

450

451 “Urgent care”, a model of episodic care delivery that is primarily the immediate
452 diagnosis, treatment, management or monitoring of acute and chronic disease, generally provided
453 on a walk-in basis, and not intended as the patient’s primary care provider.

454

455 “Urgent care clinic”, a clinic that provides urgent care as defined by this section.

456

457 SECTION 13. Said chapter 111 is hereby amended by striking out section 53D, as so
458 appearing, and inserting in place thereof the following section:-

459

460 (a) Any acute hospital, non-acute hospital, ambulatory surgical center, urgent care clinic,
461 or limited services clinic licensed under this chapter shall ensure the provision of services to
462 individuals through the use of hollow-bore needle devices or other technology that minimize the
463 risk of injury to health care workers from hypodermic syringes or needles, in accordance with
464 rules and regulations promulgated pursuant to subsection (b).

465

466 (b) The department shall promulgate rules and regulations requiring the use, at all acute
467 hospitals, non-acute hospitals, ambulatory surgical centers, urgent care clinics, and limited
468 services clinics, of only such devices which minimize the risk of injury to health care workers
469 from needlestick and sharps, so-called. Such rules and regulations promulgated by the
470 department shall include the following requirements:

471

472 (1) Written exposure control plans shall be developed by each acute hospital, non-acute
473 hospital, ambulatory surgical center, urgent care clinic, or limited services clinic that include an

474 effective procedure for identifying and selecting existing sharps prevention technology, so-
475 called, of the types specified by the department.

476

477 (2) Sharps injury prevention technology shall be included as engineering or work practice
478 controls, except in cases where the employer or other appropriate party can demonstrate
479 circumstances in which the technology does not promote employee or patient safety or interferes
480 with a medical procedure. Those circumstances shall be specified by the employer and shall
481 include, but not be limited to, circumstances where the technology is medically contraindicated
482 or not more effective than alternative measures used by the employer to prevent exposure
483 incidents. In all cases the department shall make the final determination as to whether an
484 employer or other appropriate party has demonstrated in a satisfactory manner circumstances
485 which warrant an exemption from the inclusion of sharps injury prevention technology.

486

487 (3) Information concerning exposure incidents shall be recorded in a sharps injury log to
488 be kept within such acute hospitals, non-acute hospitals, ambulatory surgical centers, urgent care
489 clinics, or limited services clinics and reported annually to the department, including but not
490 limited to, the type and brand of device involved in the incident. Such logs shall be used as the
491 basis for continuing quality improvement in reducing sharps injuries through the provision of
492 education and the procurement of improved products. Such logs shall be kept confidential and
493 shall be used only for the intended purposes of this section.

494

495 (4) Written exposure control plans shall be updated when necessary to reflect progress in
496 sharps prevention technology as determined by the department.

497

498 (c) The department shall promulgate all rules and regulations pursuant to this section in
499 consultation with an advisory committee composed of, but not limited to: the department's
500 director of infectious disease, a consumer to be selected by the commissioner, a technical expert
501 to be selected by the commissioner, and a representative from the Massachusetts Nurses
502 Association, the Massachusetts Association of Occupational and Environmental Medicine, the
503 Massachusetts Medical Society and the Massachusetts Hospital Association.

504

505 The department, in consultation with the advisory committee, shall compile and maintain
506 a list of needleless systems, needles and sharps, so-called, with engineered injury protections
507 meeting the purposes of this section. The list shall be available to assist employers in complying
508 with rules and regulations promulgated in accordance with this section.

509

510 SECTION 14. Said chapter 111 is hereby amended by striking out section 53E, as so
511 appearing, and inserting in place thereof the following section:-

512

513 The department shall promulgate regulations for the establishment of a patient and family
514 advisory council at each hospital and ambulatory surgical center in the commonwealth. The
515 council shall advise the hospital or ambulatory surgical center on matters including, but not

516 limited to, patient and provider relationships, institutional review boards, quality improvement
517 initiatives and patient education on safety and quality matters. Members of a council may act as
518 reviewers of publicly reported quality information, members of task forces, members of awards
519 committees for patient safety activities, members of advisory boards, participants on search
520 committees and in the hiring of new staff, and may act as co-trainers for clinical and nonclinical
521 staff, in-service programs, and health professional trainees or as participants in reward and
522 recognition programs.

523

524 SECTION 15. Said chapter 111 is hereby amended by striking out section 53F, as so
525 appearing, and inserting in place thereof the following section:-

526

527 The department shall require acute care hospitals, ambulatory surgical centers, urgent
528 care clinics, and limited services clinics to have a suitable method for health care staff members,
529 patients and families to request additional assistance directly from a specially-trained individual
530 if the patient's condition appears to be deteriorating. The acute care hospital, ambulatory surgical
531 center, urgent care clinic, or limited services clinic shall have an early recognition and response
532 method most suitable for the hospital's, ambulatory surgical center's, urgent care clinic's, or
533 limited services clinic's needs and resources, such as a rapid response team. The method shall be
534 available 24 hours per day.

535

536 SECTION 16. Section 203 of said chapter 111, as so appearing, is hereby amended by
537 striking out paragraphs (a) through (d), inclusive, and inserting in place thereof the following
538 four paragraphs:-

539

540 (a) The by-laws of every licensed or public hospital, the by-laws of all medical staffs, and
541 the by-laws of all ambulatory surgical centers and urgent care clinics shall contain provisions for
542 reporting conduct by a health care provider that indicates incompetency in his specialty or
543 conduct that might be inconsistent with or harmful to good patient care or safety. Said by-laws
544 shall direct a procedure for investigation, review and resolutions of such reports.

545

546 (b) Whenever, following review by a medical peer review committee of a licensed or
547 public hospital, ambulatory surgical center, or urgent care clinic determination is reached that a
548 health care provider's privileges should be suspended in the best interests of patient care, such
549 committee shall immediately forward the recommendation to the executive committee of the
550 medical staff and the institution's board of trustees for action. A provider whose privileges are
551 suspended shall be entitled to notice and a prompt hearing following suspension, in accordance
552 with the institution's medical staff by-laws.

553

554 (c) An individual or institution, including a licensed or public hospital, ambulatory
555 surgical center, urgent care clinic, physician credentialing verification service operated by a
556 society or organization of medical professionals for the purpose of providing credentialing

557 information to health care entities, or licensed nursing home reporting, providing information,
558 opinion, counsel or services to a medical peer review committee, or participation in the
559 procedures required by this section, shall not be liable in a suit for damages by reason of having
560 furnished such information, opinion, counsel or services or by reason of such participation,
561 provided, that such individual or institution acted in good faith and with a reasonable belief that
562 said actions were warranted in connection with or in furtherance of the function of said
563 committee or the procedures required by this section.

564

565 (d) Every licensed hospital, ambulatory surgical center, and urgent care clinic, as a
566 condition of licensure, and every public hospital shall be required to participate in risk
567 management programs established by the board of registration in medicine pursuant to section
568 five of chapter one hundred and twelve; provided, however, that licensed or public hospitals,
569 ambulatory surgical centers, and urgent care clinics which participate in pre-existing risk
570 management programs may be exempted by regulations of the board from the requirements of
571 this paragraph.