

HOUSE No. 1849

The Commonwealth of Massachusetts

EXECUTIVE DEPARTMENT



DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

February 17, 2011

[Governors Message Body Text]

Respectfully submitted,

Deval L. Patrick,
Governor

HOUSE No. 1849

A message from His Excellency the Governor recommending legislation improving the quality of health care and controlling costs by reforming health systems and payments.

The Commonwealth of Massachusetts

—————
In the Year Two Thousand Eleven
—————

An Act improving the quality of health care and controlling costs by reforming health systems and payments.

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

1 February 17, 2011.

2 To the Honorable Senate and House of Representatives:

3 I am filing for your consideration a bill entitled, “An Act Improving the Quality of Health
4 Care and Controlling Costs by Reforming Health Systems and Payments.” Through our
5 collective efforts during the past several years, Massachusetts has become a national leader in
6 health care reform. Today, we have an opportunity to expand that leadership by ensuring that
7 health care is universally affordable.

8 The bill I am filing will lower health care costs for consumers while providing the health
9 care industry both the incentives and the freedom to innovate and find lower cost ways to deliver
10 better care.

11 This legislation will realize these goals by:

- 12 • Giving the Commissioner of the Division of Insurance authority to consider
13 several new criteria when deciding whether or not to disapprove excessive health insurance
14 premium increases;
- 15 • Encouraging the formation and use of integrated care organizations, comprised of
16 groups of providers that work together to achieve improved health outcomes for patients at lower
17 costs;
- 18 • Establishing benchmarks and timelines for the transition to “alternatives to fee for
19 service” and the predominant use of integrated care organizations by 2015;
- 20 • Encouraging the use of payment methods (such as global payments, bundled
21 payments, etc.) that will decrease total per capita expenditures on health care, and the rate of
22 growth in expenditures for health care in the Commonwealth, and improve the efficiency,
23 effectiveness and quality of health care delivery;
- 24 • Ensuring transparency and accuracy of payer and provider costs, provider
25 payments, clinical outcomes, quality measures, and other information which is necessary to
26 discern the value of health services;
- 27 • Empowering the relevant state entities to monitor and address disparities in the
28 health care market that contribute to high health care costs; and
- 29 • Discouraging the practice of defensive medicine and improving the quality of
30 health care by requiring open communication between providers and patients during a “cooling
31 off period” before litigation can commence and limiting the use of a physician’s apology in
32 litigation.

33 With the passage of the health care reform bill in 2006, the Commonwealth of
34 Massachusetts became the first state in the nation to take on the challenge of ensuring access to
35 health care for all its residents. This is the year we take on the challenge of ensuring that high
36 quality care is also universally affordable.

37 I urge your prompt and favorable consideration of this legislation.

38 Respectfully submitted,

39 DEVAL L. PATRICK,

40 Governor.

41

42 The Commonwealth of Massachusetts

43 _____

44 In the Year Two Thousand Eleven.

45 _____

46 AN ACT IMPROVING THE QUALITY OF HEALTH CARE AND CONTROLLING
47 COSTS BY REFORMING HEALTH SYSTEMS AND PAYMENTS.

48 Whereas, The deferred operation of this act would tend to defeat its purpose, which is
49 forthwith to improve the quality of health care and control costs by reforming health systems and
50 payments, therefore it is hereby declared to be an emergency law, necessary for the immediate
51 preservation of the public health and convenience.

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

54

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70 Finding and Purposes

71 SECTION 1. The general court finds that:

72 (a) The commonwealth leads the nation in the percentage of residents who have health
73 insurance, with more than 98% covered. The rate of insurance coverage has increased for all
74 income levels and among all racial and ethnic groups in the commonwealth. As of June 2010,
75 more than 400,000 people in the commonwealth had insurance who had previously been
76 uninsured before enactment of the 2006 health care reform act. Furthermore, the proportion of
77 employers offering health insurance to their employees has increased to 76%, while the national
78 average is 69%. While the commonwealth ranks first in the nation in providing access to its
79 residents, the Commonwealth Fund ranks Massachusetts thirty-third on avoidable hospital use
80 and costs. This ranking reflects the need to improve quality and coordination of care. In
81 addition Medicare reimbursements per Massachusetts enrollee are among the highest in the
82 nation reflecting the overall higher cost of health care compared to the rest of the nation.

83 (b) The rate of increase in health care costs has outpaced growth in the economy and
84 threatens the financial health of individuals and businesses, while squeezing out other priorities
85 for government spending. Left unchecked, per capita health care spending in the commonwealth
86 is expected to continue to outpace the annual rise in the gross domestic product, with total health
87 care spending reaching \$123 billion by 2020.

88 (c) Many of the cost and quality problems in health care are either caused or exacerbated
89 by the current fee-for-service payment system. Under most current health care payment
90 arrangements physicians, hospitals, and other providers receive more revenue for delivering
91 more services, not for delivering higher quality services or services that are more effective in

92 improving an individual's health. Providers who keep individuals well or help them manage
93 chronic medical problems effectively are not rewarded for those outcomes. In fact, providers are
94 often penalized if visits to the doctor are avoided, tests or procedures are appropriately not
95 scheduled and hospital beds are not filled. While many of the advances in medicine and the
96 understanding of disease processes indicate that providers can act to prevent chronic diseases,
97 help patients manage those diseases to avoid complications, and prevent adverse outcomes from
98 occurring, achieving these outcomes requires providers to deliver care across many settings and
99 to work as a team. Yet separate payments are made to physicians, hospitals and other health care
100 providers involved in an individual's care. There are few incentives for providers to coordinate
101 their services and many preventive and care coordination functions are not reimbursed or are
102 poorly reimbursed.

103 (d) In addition there are wide variations in prices paid by insurers to providers for the
104 same or similar services. There is a need for greater transparency about the rationale for these
105 differences in payments in order to maintain access to the full continuum of health care services
106 from primary care to quaternary care.

107 (e) Therefore, it is necessary to enact legislation to limit health care costs while
108 improving health care services to residents of the commonwealth. This act achieves those goals
109 by:

110 (i) Encouraging the formation of integrated care organizations, commonly referred to as
111 accountable care organizations, comprised of connected or integrated groups of health care
112 providers that achieve improved health outcomes and lower the costs of care.

113 (ii) Providing for payment methods that will decrease total per capita expenditures, and
114 the rate of growth in expenditures for health care in the commonwealth, and improve the
115 efficiency, effectiveness and quality of its health care delivery systems. Payments will move
116 from predominant fee-for-service to global and other alternative payment methods for the
117 provision of health care services. All public and private payers in the commonwealth will move
118 to reimbursements that are based on the quality rather than the volume of services, and employ
119 comparable approaches to clinical risk adjustment and payment methodologies for comparable
120 patient groups.

121 (iii) Ensuring transparency of payer and provider costs, provider payments, clinical
122 outcomes, quality measures, and other information is necessary to discern the value of health
123 services; and ensure such information is accurate, relevant and publicly available. All residents
124 of the commonwealth must have the information they need to make informed choices among
125 primary care clinicians, other providers and integrated systems.

126 (iv) Providing a transition period for improving the delivery system and for adopting
127 alternative payments. Upon passage of this act, the division of insurance will have additional
128 authority to take into account provider rate increases and provider rate disparities in considering
129 whether premium increases are justified.

130 (v) Enacting strong safeguards for consumers to ensure continued access for all.

131 Powers of Attorney General

132 SECTION 2. Chapter 12 of the General Laws is hereby amended by inserting after
133 section 11L the following section:-

134 Section 11M. The attorney general shall:

135 (a) monitor trends in the health care market during the reorganization of the health care
136 system; including but not limited to trends in ACO size and composition, consolidation in the
137 ACO and provider markets, payer contracting trends, impact on patient selection of provider and
138 ACO, and other market effects of the transition from fee-for-service forms of payment.

139 (b) in consultation with the coordinating council, take appropriate action to prevent
140 excess consolidation or collusion of providers or ACOs and to remedy these or other related anti-
141 competitive dynamics in the health care market;

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

148 As used in this section, terms shall have the meanings assigned by section 1 of chapter
149 118I.

150 SECTION 3. Chapter 93A of the General Laws is hereby amended by adding the
151 following section:

152 Section 115. A health care provider, as defined in section 1 of chapter 176O, shall not
153 recoup or attempt to recoup amounts in excess of the amounts charged to carriers pursuant to
154 section 5A of chapter 176O by increasing charges to other health benefit plans or other payers.

155 The attorney general may adopt regulations enforcing this section, which shall include
156 requirements for identifying and enforcing noncompliance and penalties for noncompliance.

157 SECTION 4. The attorney general shall analyze all state and federal laws and regulations
158 that have any impact on the implementation of this act, including but not limited to state and
159 federal antitrust provisions, and not later than April 1, 2012 or 180 days after enactment of the
160 act, whichever is later, submit a report to the joint committee on health care financing and to the
161 coordinating council established by chapter 118I of the General Laws. The report shall: (a)
162 analyze the sufficiency of current state and federal antitrust law to provide adequate remedies
163 and market intervention tools for appropriate protection of competitive markets and price
164 regulation relative to the transition to accountable care organization and alternative payment
165 methodologies for the delivery of health services in the commonwealth; (b) recommend any
166 amendments to such laws to improve the adequacy of remedies and interventions available to
167 protect markets against anti-competitive trends; and (c) make specific recommendations for any
168 other statutory and regulatory changes to create sufficient tools and authority to adequately
169 protect the interests of consumers and purchasers in sustaining an open and competitive market
170 for the purchase of health care services.

171 Health Information Technology Council

172 SECTION 5. Section 6D of chapter 40J of the General Laws is hereby amended by
173 striking out subsection (b), as amended by section 97 of chapter 240 of the acts of 2010, and
174 inserting in place thereof the following subsection:-

175 (b) There shall be a health information technology council within the corporation. The
176 council shall advise the institute on the dissemination of health information technology across

177 the commonwealth, including the deployment of electronic health records systems in all health
178 care provider settings that are networked through a statewide health information exchange.

179 The council shall consist of 18 members, as follows: 1 shall be the secretary of health and
180 human services, who shall serve as the chair; 1 shall be the secretary of administration and
181 finance or designee; 1 shall be the secretary of housing and economic development or designee;
182 1 shall be the director of the office of Medicaid or designee; 1 shall be the commissioner of
183 public health; and 13 shall be appointed by the governor, of whom at least 1 shall be an expert in
184 health information technology, 1 shall be an expert in law and health policy, and 1 shall be an
185 expert in health information privacy and security; 1 shall be from an academic medical center; 1
186 shall be from a community hospital; 1 shall be from a community health center; 1 shall be from a
187 long term care facility; 1 shall be from large physician group practice; 1 shall be from a small
188 physician group practice; 1 shall represent health insurance carriers; and 3 additional members
189 shall have experience or expertise in health information technology. The council may consult
190 with parties, public or private, that it considers desirable in exercising its duties under this
191 section, including persons with expertise and experience the development and dissemination of
192 electronic health records systems, and the implementation of electronic health record systems by
193 small physician groups or ambulatory care providers, as well as persons representing
194 organizations within the commonwealth interested in and affected by the development of
195 networks and electronic health records systems, including, but not limited to, persons
196 representing local public health agencies, licensed hospitals and other licensed facilities and
197 providers, private purchasers, the medical and nursing professions, physicians, health insurers
198 and health plans, the state quality improvement organization, academic and research institutions,
199 consumer advisory organizations with expertise in health information technology and other

200 stakeholders as identified by the secretary of health and human services. Appointive members of
201 the council shall serve for terms of 2 years or until a successor is appointed. Members shall be
202 eligible to be reappointed and shall serve without compensation.

203 The members of the council shall be deemed to be directors for purposes of the fourth
204 paragraph of section 3. Chapter 268A shall apply to all council members, except that the council
205 may purchase from, sell to, borrow from, contract with or otherwise deal with any organization
206 in which any council member is in anyway interested or involved; provided, however, that such
207 interest or involvement shall be disclosed in advance to the council and recorded in the minutes
208 of the proceedings of the council; and provided further, that no member shall be deemed to have
209 violated section 4 of said chapter 268A because of his receipt of his usual and regular
210 compensation from his employer during the time in which the member participates in the
211 activities of the council.

212 Expansion of Medical Peer Review

213 SECTION 6. Section 1 of chapter 111 of the General Laws, as appearing in the 2008
214 Official Edition, is hereby amended by striking out, in line 38, the words “one hundred and
215 seventy-six G” and inserting in place thereof the following words:- 176G or within an
216 accountable care organization certified by the division of health care finance and policy under
217 chapter 118I.

218 Division of Health Care Resource Planning

219 SECTION 7. Section 25B of chapter 111 of the General Laws, as appearing in the 2008
220 Official Edition, is hereby amended by inserting after the word “minimum”, in line 118, the
221 following words:- ; or as further determined by the state health plan.

222 SECTION 8. The definition of “Substantial change in services” in said section 25B of
223 said chapter 111, as so appearing, is hereby further amended by striking out the last sentence and
224 inserting in place thereof the following 2 sentences:- Any increase in bed capacity of more than 4
225 beds for any hospital licensed pursuant to section 51 shall constitute a substantial change in
226 service. The department may further define substantial change in service in accordance with the
227 state health plan.

228 SECTION 9. The sixth paragraph of section 25C of said chapter 111, as so appearing, is
229 hereby further amended by adding the following sentence:- Any such determination by the
230 department shall be consistent with the state health plan issued by the health planning council
231 pursuant to section 25L.

232 SECTION 10. Said chapter 111 is hereby further amended by inserting after section 25E
233 the following section:-

234 Section 25E½. (a) There shall be in the department a division of health planning, in this
235 section called the division. The division shall develop a state health plan every 2 years, amended
236 more frequently as needed.

237 (b) There shall be in the department a health planning council consisting of the
238 commissioner or designee, the director of the office of Medicaid or designee, the commissioner
239 of health care finance and policy or designee, the secretary of health and human services or
240 designee, the director of the division, and 3 members appointed by the governor, of whom at
241 least 1 shall be a health economist; at least 1 shall have experience in health policy and planning,
242 and at least 1 shall have experience in health care market planning and service line analysis. The

243 health planning council shall advise the division and shall oversee and issue the state health plan
244 developed by the division.

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

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

253 Powers of Office of Patient Protection

254 SECTION 11. Paragraph (a) of section 217 of chapter 111 of the General Laws, as
255 amended by section 8 of chapter 288 of the acts of 2010, is hereby further amended by adding
256 the following clause:

257 (8) establish by regulation, after consulting the coordinating council established by
258 chapter 118I, procedures and rules relating to appeals by consumers from accountable care
259 organizations, and to conduct hearings and issue rulings on appeals brought by ACO consumers
260 that are not otherwise properly heard through the consumer's payer or provider.

261

262 Powers of Division of Health Care Finance and Policy

263 SECTION 12. Chapter 118G of the General Laws is hereby amended by adding the
264 following section:-

265 Section 42. As used in this section, terms shall have the meanings assigned by section 1
266 of chapter 118I. To facilitate a transition to a health care market where global and other
267 alternative payment methodologies are the norm, the division shall monitor health care
268 expenditures across the commonwealth and issue regulations consistent with the following:

269 (a) In consultation with the coordinating council, and pursuant to this chapter, the
270 division shall collect, monitor, evaluate, and issue reports documenting and analyzing costs and
271 payments for health care services in the commonwealth and shall further:

272 (1) Establish by regulation benchmarks for expanding the use of alternative payment
273 methodologies and reducing the use of fee-for-service methodologies by payers and providers for
274 the purpose of adopting alternative payment methods across the health care industry by the end
275 of the year 2015 and for the purposes of lowering annual increases in total medical expenditures.
276 Such benchmarks shall be consistent with the provisions of section 5A of chapter 176O and any
277 regulations adopted under section 5A;

278 (2) Establish by regulation standards for alternative payment methodologies to be utilized
279 in contracts between payers and ACOs and other providers consistent with the following
280 requirements. All payers shall develop alternative payment methodologies consistent with
281 regulations adopted by the division for the provision of integrated health care services to ACO
282 patients and shall offer these methodologies to compensate ACOs. Payers may include
283 additional payments for services provided to patients in addition to integrated health care
284 services, which may include, but not be limited to, home health and chronic/rehabilitation

285 services. The costs of integrated health care services shall be included in the cost base for the
286 establishment of any alternative payment method to be used by payers. All contracts between
287 payers and ACOs that contain a provision for shared savings between the provider and the payer
288 shall contain a mechanism to return a percentage of the savings to the ACO members.

289 (3) Establish requirements for disclosure to the division of ACO costs, and of payments
290 made by payers to ACOs;

291 (4) Require each payer to submit documentation to the division at least annually, certified
292 by the payer's chief financial officer, which (i) demonstrates that the rates of payment under
293 contracts with providers and ACOs in the upcoming year can be reasonably expected to result in
294 spending not in excess of relevant cost containment benchmarks and growth rates established by
295 the division, and (ii) shows the actual aggregate spending growth rate under the most recent
296 contract year for all contracts in effect with providers and ACOs, the actual spending growth rate
297 for all ACOs, and the actual spending growth rate for all other providers under contract with
298 each payer; provided further that, the division may require additional reporting, as it deems
299 necessary to properly monitor cost growth trends in the health care market;

300 (5) Monitor compliance by ACOs, providers, and payers with requirements established
301 pursuant to this chapter and any implementing regulations promulgated by the division;
302 achievement of benchmarks toward use of global and alternative payment methods by payers;
303 cost growth trends in health care sector of the commonwealth's economy; and cost growth trends
304 under global and alternative payment methodologies utilized by payers in the commonwealth;

305 (6) Hold hearings to determine appropriate cost growth and other benchmarks for the
306 transition to the use of global and alternative payment methods, and payment limits for health
307 care services;

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

312 Notwithstanding any other provision of this section, the division shall encourage and
313 assist providers with voluntary adoption of alternative payment methodologies as much as
314 practicable relative to funding and resources available to the division under this chapter.

315 (b) The division shall promote transparency and information dissemination in the health
316 care system, including pricing, purchasing, contracting, performance measurement and quality
317 outcomes and accordingly shall:

318 (1) Collect from payers, providers, and ACOs data pertaining to health care costs,
319 payments, competition among payers, providers and ACOs, and other matters relevant to its
320 authority and duties under this section; provided that the division shall coordinate with other
321 agencies of the commonwealth to obtain data already required to be reported by providers or
322 payers to such agencies;

323 (2) Analyze such data to assess health care cost trends and the impact of the
324 transition from fee-for-service payments to alternative payment methodologies; and

325 (3) Include its analysis in the annual report; but any data submitted pursuant to this
326 subsection shall be classified as either (i) subject to release or publication or (ii) protected under
327 a promise of confidentiality under subclause (g) of clause Twenty-sixth of section 7 of chapter 4.

328 (c) To support the transition to alternative payment methodologies, the division, in
329 consultation with the coordinating council, shall:

330 (1) By March 31, 2012, document, categorize and publish all current payment
331 arrangements in the commonwealth between payers and providers;

332 (2) Establish, facilitate and support transitional payment methodologies through pilot
333 programs and other interim programs which have as their objective the modification of fee-for-
334 service payment methods in a manner which creates incentives for higher quality care and more
335 effective, efficient care delivery under alternative payment methods, including but not limited to
336 the following:

337 a) Global payment with limits on the financial risk of ACOs, partial global payment
338 and gainsharing with pay for performance; practice expense capitation with gainsharing, care
339 management payments; bundled payments, episode-based payments, pay for performance; and
340 shared savings;

341 b) Mechanisms to narrow the gap between payments to different providers for the
342 same services;

343 c) Interim medical and social risk adjustment factors and measures;

344 d) Methodologies to account for the following costs: (i) medical education; (ii)
345 stand-by services and emergency services, including but not limited to trauma units, burn units;

346 (iii) services provided by disproportionate share hospitals or other providers serving underserved
347 populations; (iv) research; (v) care coordination and community based services provided by
348 allied health professionals; and (vi) the use and continued advancement of medical technology
349 and pharmacology;

350 (3) Evaluate cost growth trends in any interim payment methodologies used during
351 the transition to alternative payment methodologies, including pilot programs, for cost
352 effectiveness and impact on quality of care and patient choice, and shall report and publish its
353 findings to the coordinating council, the governor and the joint committee on health care
354 financing annually, regarding which methodologies, based on analysis and comparison over
355 time, are most effective in promoting efficient and coordinated care.

356 (d) With the input of expert advice, and in consultation with the coordinating council, the
357 division shall evaluate and take measures to address ERISA restrictions and recommend
358 potential incentives for employers who participate in self-funded plans to participate in
359 alternative payment methods;

360 (e) The division shall study and evaluate best practices for the provision of high quality,
361 efficient care in other states and nations for potential adoption into the alternative payment
362 methodologies prescribed or monitored under this chapter.

363 (f) The division shall submit a written report annually to the coordinating council on all
364 of its findings from its monitoring obligations, evaluations performed, and regulations
365 promulgated pursuant to its obligations and authority under this chapter; provided, that such
366 report shall include annual updates to all information required to be published in section (c) (2)
367 above; provided further, that such report shall also include a plan for achieving all milestones

368 and benchmarks relating to the transition to alternative payment methodologies including
369 adjustments for risk and other factors, and achievement of cost containment; and provided
370 further, that the division may be required to submit additional or supplemental reports or
371 analyses at the request of the coordinating council.

372 (g) The commissioner of the division or designee shall participate in all meetings of the
373 coordinating council, and shall participate in making recommendations to other agencies
374 represented on the coordinating council to promote the goals and purposes of this chapter. The
375 commissioner shall adopt or otherwise implement all recommendations made by the
376 coordinating council to the division.

377 Health Services System and Payment Reform, including Coordinating Council

378 SECTION 13. Sections 16J to 16L, inclusive, of chapter 6A of the General Laws are
379 hereby repealed.

380 SECTION 14. The General Laws are hereby amended by inserting after chapter 118H
381 the following chapter:-

382 CHAPTER 118I.

383 HEALTH SERVICES SYSTEM AND PAYMENT REFORM.

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

386 “Accountable care organization” or “ACO”, an entity comprised of provider groups
387 which operates as a single integrated organization that accepts at least shared responsibility for
388 the cost and primary responsibility for the quality of care delivered to a specific population of

389 patients cared for by the groups' clinicians; which operates consistent with principles of a patient
390 centered medical home and satisfies the other requirements of this chapter; which has a formal
391 legal structure to receive and distribute savings; and which complies with any federal
392 requirements applicable to ACOs, however named, which have been or may be enacted or
393 adopted in law or regulation.

394 "ACO network provider", a provider that by contract or corporate structure participates in
395 a specific ACO. Certain providers that are not primary care providers may be ACO network
396 providers in more than one ACO, as set forth in regulation by the division.

397 "ACO patient", an individual who receives integrated health care services through an
398 ACO, and for whom such services are paid by a payer to the ACO pursuant to the alternative
399 payments set forth in this chapter.

400 "Alternative payment contract", an agreement between a payer and an ACO or other
401 provider in which reimbursement available under the agreement is pursuant to an alternative
402 payment methodology, as defined in this chapter, for services provided by an ACO or other
403 provider. The contract shall include at least some performance based quality measures with
404 associated financial rewards or penalties, or both.

405 "Alternative payment methodologies or methods", methods of payment that are not fee-
406 for-service based and compensate ACOs and other providers for the provision of health care
407 services, including but not limited to shared savings arrangements, bundled payments, episode-
408 based payments, and global payments, as defined in regulations adopted by the division of health
409 care finance and policy. No payment based on the fee-for-service methodology shall be
410 considered an alternative payment.

411 “Coordinating council”, the health services system and payment reform coordinating
412 council established by section 2.

413 “Division”, the division of health care finance and policy.

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

417 “Health benefit plan”, as defined in section 1 of chapter 176G.

418 “Integrated health care services”, health care services relating to the treatment of certain
419 conditions, including but not limited to all conditions required to be covered under regulations of
420 the commonwealth health insurance connector authority defining the core services and a broad
421 range of medical benefits required for minimum creditable coverage and as adopted through
422 regulation by the division in accordance with this chapter.

423 “Office of patient protection”, the office within the department of public health
424 established by section 217 of chapter 111.

425 “Patient centered medical home”, any primary care practice which is organized in
426 accordance with standards of the National Committee for Quality Assurance or as otherwise may
427 be defined by regulation by the division, and which incorporates the principles set forth in the
428 commonwealth’s patient centered medical home initiative.

429 “Payer”, any entity, other than an individual, that pays providers or ACOs for the
430 provision of health care services. The term “payer” shall include both governmental and
431 commercial entities, but excludes ERISA plans.

432 “Performance incentive payment” or “pay-for-performance”, an amount paid to an ACO
433 by a payer for achieving certain quality measures as defined in this chapter. Performance
434 incentive payments shall comply with this chapter, regulations of the division of health care
435 finance and policy, and the contract between an ACO and a payer.

436 “Performance penalty”, an amount paid by an ACO to a payer or a reduction in the
437 payments made by a payer to an ACO for failing to achieve certain quality measures as herein
438 defined. Performance penalty provisions and their implementation shall comply with this
439 chapter, any regulations of the division of health care finance and policy, and the contract
440 between an ACO and a payer.

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

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

445 “Purchaser”, a private employer, individual, or government entity that buys health care
446 services or insurance products on behalf of itself, its employees, or individuals enrolled in its
447 programs.

448 “Quality measures”, objective benchmarks established in accordance with nationally
449 accepted performance metrics and as otherwise permitted under this chapter for assessing
450 provider performance which may be the subject of a performance incentive payment or
451 performance penalty, and which shall include the following: patient experience satisfaction and
452 engagement measures, and health outcome measures and process compliance measures, and
453 others as may be further detailed in regulations of the division.

454

455 Section 2. (a) There shall be an agency known as the health services system and payment
456 reform coordinating council within, but not subject to the control of, the executive office of
457 health and human services. The coordinating council shall establish a plan of action, a timeline,
458 benchmarks, and standards to ensure and facilitate (i) the establishment of ACOs throughout the
459 commonwealth by June 2015, (ii) the transition to utilization of alternative payment methods by
460 all payers by June 2015, and (iii) the protection of quality, access and patient choice of primary
461 care provider and accountable care organization for the residents of the commonwealth. The
462 coordinating council shall coordinate and make recommendations to agencies and entities
463 represented on the council relating to pricing and reimbursement methods and quality measures
464 to be utilized in contracts with payers of accountable care organizations, minimum criteria and
465 other parameters for the formation of accountable care organizations and market parameters
466 relevant to the development of fair, effective, efficient and sustainable global payment or other
467 alternative payment methodologies in the purchase of health care services, including, at a
468 minimum, integrated health care services for patients in the commonwealth by the target dates
469 set by the coordinating council under the provisions of this chapter, and any other measures
470 necessary to ensure that the growth rate of total medical expenditures in the commonwealth is
471 reasonable and not excessive. The coordinating council shall be a public body for purposes of
472 sections 18 to 25, inclusive, of chapter 30A.

473 (b) The coordinating council shall consist of the secretary of health and human services,
474 the commissioner of mental health, the director of Medicaid, the commissioner of public health,
475 the commissioner of health care finance and policy, the commissioner of insurance, the executive
476 director of the commonwealth health insurance connector authority, the secretary of

477 administration and finance or designee, the secretary of housing and economic development or
478 designee, and the director of the Massachusetts health institute. The secretary of health and
479 human services shall chair the coordinating council.

480 (c) The coordinating council shall consult regularly with an advisory committee, to be
481 known as the health care innovation advisory committee, which shall consist of 18 members, 1
482 of whom shall be the attorney general or designee, 1 of whom shall be the inspector general or
483 designee, 2 of whom shall be representatives of the acute care hospitals in the commonwealth
484 appointed by the Massachusetts Hospital Association, 1 of whom shall be a representative of the
485 Massachusetts Association of Health Plans, 1 of whom shall be a representative of Blue Cross
486 Blue Shield of Massachusetts; and 10 other members appointed by the governor with expertise
487 and knowledge of health care systems and payments, 2 of whom shall be physicians certified in
488 a specialty, 2 of whom shall be primary care physicians, 1 of whom shall be an advanced
489 practice nurse with expertise in the patient centered medical home model of health care delivery,
490 1 of whom shall be a representative of behavioral health providers, 1 of whom shall be a
491 representative of consumer health advocacy organizations, 1 of whom shall be a representative of
492 a large, self-insured employer, 1 of whom shall be a representative of small employers, 1 of
493 whom shall be a representative of organized labor representing health workers, 1 of whom shall
494 be a representative of organized labor representing other workers, and 1 of whom shall be an
495 expert in health policy.

496 (d) No member of the coordinating council shall be employed by, a consultant to, a
497 member of the board of directors of, affiliated with, a representative of or have any fiduciary
498 duty to a trade association of, an agent or broker of, or have an ownership interest, or financial

499 interest in or fiduciary duty to, a carrier or other insurer, a health care provider, a health care
500 facility or health clinic while serving on the coordinating council.

501 Section 3. (a) The division shall staff and support the coordinating council. The division
502 shall facilitate the establishment of ACOs and ensure consistency and efficacy in the
503 establishment and use of quality measures throughout the commonwealth to promote patient-
504 centered, timely, safe care for individuals in the commonwealth. The division shall establish a
505 plan of action, a timeline, benchmarks, and standards to ensure and facilitate (i) the
506 establishment of accountable care organizations throughout the commonwealth by June 2015,
507 and (ii) the protection of quality, access and patient choice of primary care provider and
508 accountable care organization for the residents of the commonwealth. The division shall
509 establish by regulation minimum criteria for the formation of accountable care organizations and
510 parameters for quality measurements to be used in the evaluation of the performance of
511 accountable care organizations.

512 (b) No staff member, employee, or other agent of the division shall be employed by, a
513 consultant to, a member of the board of directors of, affiliated with, a representative of or have
514 any fiduciary duty to a trade association of, an agent or broker of, or have an ownership interest,
515 or financial interest in or fiduciary duty to, a carrier or other insurer, a health care provider, a
516 health care facility or health clinic while employed by or otherwise providing services to the
517 division.

518 Section 4. The coordinating council shall:

519 (a) monitor and assure inter-agency consistency and appropriate consumer protections
520 with the implementation of health care payment and delivery reform by state and private entities

521 in the commonwealth by coordinating actions among state agencies and ensuring, where
522 appropriate, coordination with federal agencies and ensuring that regulations and other forms of
523 official guidance are issued by the appropriate agencies concerning: (i) the establishment of
524 ACOs throughout the commonwealth and (ii) the transition to alternative payment
525 methodologies for integrated and non-integrated delivery of health care services to be used as an
526 alternative to fee-for-service payments.

527 (b) monitor and report on the health care expenditures across the commonwealth and
528 recommend actions appropriate and necessary to agencies and entities represented on the
529 coordinating council to contain the growth in health care costs incurred by all sectors of the
530 health care economy, including the costs of payers, purchasers, plans, insurers, government and
531 individuals.

532 (c) review and evaluate reports related to health services system and payment reform
533 from the division of insurance, the division of health care finance and policy, the office for health
534 care innovation, and the executive office of health and human services, and to publish these
535 reports when final;

536 (d) ensure that all data collection, analysis, and other submission requirements
537 established under this chapter are implemented in a manner which promotes administrative
538 simplification, avoids duplication, and does not impose an undue burden on any entity or
539 individual;

540 (e) make recommendations to agencies and entities represented on the coordinating
541 council regarding all aspects of the transition to alternative payment methodologies, ACO
542 models of care, and controlling the cost of health care expenditures in the commonwealth; and

543 (f) prepare and submit reports to executive and legislative bodies identified in section [7]
544 of this chapter relating to the achievement of benchmarks and other developments, evaluations,
545 regulations and measures taken by the agencies and entities represented on the coordinating
546 council in the transition to alternative payment methodologies, ACO models of care, and cost
547 containment.

548 Section 5. The division shall:

549 (a) monitor and facilitate the reform of the health care delivery system by state and
550 private entities in the commonwealth.

551 (b) adopt regulations and issue administrative bulletins and various other forms of official
552 guidance concerning:

553 (1) the establishment of ACOs throughout the commonwealth and

554 (2) the establishment of standardized measures of quality to be used in the evaluation of
555 the performance of ACOs.

556 (c) allow independent physician associations, physician-hospital organizations, and
557 various forms of integrated health care organizations and entities to qualify as an ACO if they
558 meet the criteria as set forth in this chapter and as established by the division under this section.
559 The division shall encourage and assist providers with voluntary adoption of the ACO model of
560 health care service delivery as much as practicable relative to funding and resources available to
561 the division under this chapter.

562 (d) facilitate the establishment of ACOs throughout the commonwealth, provide by
563 regulation for the certification or licensing of ACOs that meet the requirements of this chapter,

564 and by June 1, 2012 establish by regulation minimum requirements for the formation of ACOs
565 consistent with the following parameters and requirements:

566 (1) ACOs shall accept and share among their ACO network providers responsibility for
567 the delivery, management, quality, and cost of the provision of at least all integrated health care
568 services, as such terms are defined in section 3 of this chapter, to ACO patients, or other set of
569 services as may be authorized and adopted by the division under this chapter;

570 (2) ACOs may be compensated through an alternative payment method for each ACO
571 patient receiving services through the ACO, in accordance with this chapter and any regulations
572 adopted under it by the division;

573 (3) ACOs must, at a minimum, have or obtain through contractual arrangement the
574 following functional capacities:

575 a) Clinical service coordination, management, and delivery functions, including the
576 ability to provide integrated health care services through its ACO provider network in
577 accordance with the principles of a patient centered medical home; provided further, that ACOs
578 shall be required to provide primary care coordination and referral services internally and not
579 solely through contracts;

580 b) Population management functions, including health information technology and
581 data analysis tools to provide at least: (i) patient-specific encounter data; and (ii) management
582 reports on aggregate data;

583 c) Financial management capabilities, including but not limited to the management
584 of claims processing and payment functions for ACO network providers;

585 d) Contract management capabilities, including but not limited to network provider
586 creation and management functions;

587 e) Quality measurement competence, including but not limited to the ability to
588 measure and report performance relative to established measures of quality and performance
589 under standardized quality measures;

590 f) Patient and provider communications functions; and

591 g) The ability to provide behavioral health services either internally within the ACO
592 or by contractual arrangement.

593 (4) ACOs organizational structures must include consumer representations and ensure the
594 ACO decision-making reflects the views of physicians, nurses, and other providers.

595 (e) Monitor the formation of ACOs in the commonwealth, and, in consultation with the
596 coordinating council and the health care innovation advisory committee, establish any
597 benchmarks deemed necessary or appropriate to facilitate the transition of health care providers
598 and facilities into integrated care delivery systems;

599 (f) Establish safeguards against underutilization of services and protections against
600 inappropriate denials of services or treatment in connection with utilization of any alternative
601 payment method or transition to a global payment system;

602 (g) Establish safeguards against and penalties for inappropriate selection of low cost
603 patients and avoidance of high cost patients by ACOs and ACO network providers, including but
604 not limited to requiring that ACOs accept as ACO patients all individuals regardless of payer
605 source or clinical profile;

606 (h) Adopt regulations requiring that primary care clinicians shall participate in only 1
607 ACO, except as otherwise specifically permitted by the division;

608 (i) Establish parameters to measure and ensure access by disabled and other individuals
609 with chronic or complex medical conditions to appropriate specialty care;

610 (j) Establish reporting and disclosure requirements for ACOs and ACO network
611 providers, including requirements for the disclosure by ACOs relative to performance on quality
612 measures and other performance measures, and medical necessity and other criteria used in any
613 alternative payment contract or agreement;

614 (k) Consistent with the regulations adopted under section 54 of chapter 288 of the acts of
615 2010, identify by regulation appropriate quality measures and parameters for quality measures,
616 in consultation with the division of health care finance and policy and the department of public
617 health, in accordance with the following: quality measures shall be designed so that they can be
618 standard and uniform across all payers using alternative payment methodologies, and shall
619 include only evidence-based standards, standards adopted and utilized by the Centers for
620 Medicare and Medicaid Services or standards generally accepted by one or more nationally-
621 recognized quality metrics and standard setting organizations;

622

623 (l) In consultation with the department of public health, and the division of insurance, and
624 consistent with quality measurements and standards established by nationally recognized
625 professional organizations, establish parameters for clinical outcomes beyond the control of the
626 clinician for which ACOs and ACO network providers shall not be financially responsible;

627

628 (m) Monitor ACO delivery systems paid under alternative payment methods to ensure
629 that ACOs possess either internally or through contract arrangements the competencies necessary
630 to operate as an effective ACO as determined by experts in the field and professional physician
631 organizations, including but not limited to implementing a system of operational accountability
632 to drive improved performance;

633 (n) Evaluate and provide guidance through regulations relative to consumer protections
634 and any deficiencies of patient choice of provider that may arise in the transition from a fee-for-
635 service system. The division shall monitor the movement of patients from and between ACOs,
636 and shall establish parameters for out- of- ACO arrangements, as well as for patient provider
637 choice and other consumer protections;

638 (o) Establish by regulation requirements for ACOs to address consumer grievances. Any
639 individual or authorized representative of an individual who is aggrieved by restrictions on
640 patient choice, or quality of care resulting from any final ACO action may request an external
641 review by filing a request in writing with the office of patient protection of the department of
642 public health within 45 days of the individual's receipt of written notice of the final adverse
643 determination or receipt of care that fails to meet standard of care in that area or otherwise raises
644 quality of care issues;

645 (p) Monitor and evaluate provider complaints, and may establish by regulations
646 requirements for ACOs to address provider grievances;

647

648 (q) Monitor compliance by ACOs, providers, and payers with requirements established
649 pursuant to this chapter and any implementing regulations promulgated by the division; barriers
650 to entry by providers; excess consolidation of ACOs or other integrated services provider groups;
651 and the trends in patient choice among providers and ACOs;

652

653 (r) Promote transparency and information dissemination in health care system, including
654 pricing, purchasing, contracting, performance measurement and quality outcomes and
655 accordingly shall:

656 (1) collect from payers, providers, and ACOs data pertaining to quality and other matters
657 relevant to its authority and duties under this section; provided that the division shall coordinate
658 with other agencies of the commonwealth to obtain data already required to be reported by
659 providers or payers to such agencies;

660 (2) analyze such data to assess trends in performance, the impact of the transition ACO
661 delivery systems, including changes in the workforce, trends in primary care physician capacity,
662 and changes in health care provider practice operations, and including progress toward shared
663 responsibility for the needed infrastructure, legal, and technical support for providers;

664 (3) include its analysis in its annual report; but any data submitted pursuant to this
665 subsection shall be classified as either (i) subject to release or publication or (ii) protected under
666 a promise of confidentiality under of subclause (g) of clause Twenty-sixth of section 7 of chapter
667 4;

668 (4) monitor provider and ACO acquisition and implementation of health information
669 technology, and monitor compliance with standards established by the commonwealth's health
670 information technology council; and

671 (5) establish by regulation parameters and rules to require obtaining patient consent for
672 sharing information regarding patient care across all providers within a patient centered medical
673 home and ACO.

674 (s) Consistent with the regulations adopted under section 54 of chapter 288 of the acts of
675 2010, advance the study and understanding of quality measures, by:

676 (1) Evaluating current standards and measurement of current best clinical practices;

677 (2) Establishing new quality measures that advance the level of clinical practice, patient
678 satisfaction, and patient health outcomes, with particular emphasis on outcomes-based quality
679 measures;

680 (t) In developing new knowledge and standards in the areas described in this section,
681 study and evaluate the best practices for the provision of high quality, efficient care in other
682 states and nations for potential adoption into the quality measures proscribed or monitored under
683 this chapter;

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

688 (v) Submit an annual written report to the coordinating council and the health care
689 innovation advisory committee on all findings from its monitoring obligations, evaluations
690 performed, and regulations adopted pursuant to its obligations and authority under this chapter.
691 This report shall include a plan for achieving all milestones and benchmarks relating to the
692 transition to the ACO model of care and establishment of standardized quality measures; and
693 provided further, that the division may be required to submit additional or supplemental reports
694 or analyses at the request of the coordinating council.

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

698 Section 6. (a) Self-funded plans may implement alternative payment methods in
699 accordance with this chapter at their discretion and in accordance with all laws.

700 (b) To ensure participation by publicly funded health programs, the office of Medicaid,
701 the group insurance commission, the commonwealth health insurance connector authority, and
702 any other state funded insurance program shall, to the maximum extent feasible, implement
703 alternative payment methodologies and use integrated care organizations and ACOs for the
704 delivery of publicly funded health services, commencing no later than January 1, 2014.

705 Section 7. (a) The coordinating council shall prepare and submit annually a report
706 setting forth all findings, evaluations, and regulations issued by each agency represented on the
707 coordinating council and the plan and any recommendations made by the coordinating council to
708 agencies represented on the coordinating council pertaining to the transition to alternative
709 payment methodologies and ACO formation to the governor, president of the senate, the speaker

710 of the house of representatives, the chairs of the joint committee on health care financing, and the
711 chairs of the house and senate committees on ways and means. The council shall post the report
712 on the public website of the executive office of health and human services.

713 (b) The annual reports to be filed pursuant to subsection (a) shall set forth specific
714 benchmarks for the reduction of health care costs and the improvement of health care quality in
715 the commonwealth, which shall include reduction in health care costs; and which shall include at
716 least information and data regarding the following: the number and proportion of providers
717 practicing without affiliation with or participation in an ACO; the proportion of health care
718 expenditures paid using a fee-for-service form of payment; the proportion of health care
719 expenditures paid using global payment methodology; the proportion of health care expenditures
720 paid using alternative payment methods; and the proportion of patients receiving care outside of
721 an ACO; and the type of services and expenditures made through methods other than alternative
722 payment methodologies; the type of services and expenditures made through alternative payment
723 methodologies to providers that are not affiliated with an ACO; the proportion of health care
724 expenditures paid pursuant to alternative payment methodologies to providers that are not
725 affiliated with an ACO; the status of market competition for providers and ACOs; the barriers to
726 entry, if any, for an ACO; the status of patient choice of provider and ACO; the cost growth
727 trends for alternative payment method rates, in aggregate and for individual ACOs; the cost
728 growth trends for fee-for-services expenditures in the commonwealth; ACO performance ratings;
729 ACO quality ratings and trends and quality ratings and trends among providers not practicing as
730 an affiliate or participant in an ACO.

731 (c) The coordinating council shall also submit bi-annual reports to the anti-trust and
732 public protection divisions of the office of the attorney general, to provide the information and

733 data, as determined necessary by the attorney general, to perform its oversight, monitoring,
734 compliance and enforcement duties under section 11M of chapter 12.

735 Section 8. Interest on a legal judgment against an ACO shall be assessed at the federal
736 funds rate in effect at the time the judgment is entered.

737 Powers of Division of Insurance

738 SECTION 15. Subsection (b) of section 6 of chapter 176J of the General Laws, as
739 appearing in section 29 of chapter 288 of the acts of 2011, is hereby amended by adding the
740 following paragraph:-

741 In addition to the projected administrative expenses and financial information, a carrier
742 shall file information to demonstrate that the recent and projected reimbursement to health care
743 providers is consistent with section 5A of chapter 176O.

744 SECTION 16. Subsection (d) of said section 6 of said chapter 176J, as so appearing, is
745 hereby amended by adding the following paragraph:-

746 For base rate changes filed under this section, if a carrier files a base rate change that is
747 based on health care provider rates of reimbursement that are not consistent with the
748 requirements of section 5A of chapter 176O, that carrier's rate, in addition to being subject to all
749 other provisions of this chapter, shall be presumptively disapproved as excessive by the
750 commissioner as set forth in this subsection.

751 SECTION 17. Chapter 176O of the General Laws is hereby amended by inserting after
752 section 5 the following 4 sections:-

753 Section 5A.

754 (a) No carrier shall enter, renew or extend a contract or agreement with any health care
755 provider unless the rate of reimbursement in the new, renewed or extended contract increases by
756 an amount less than or equal to an amount established by the commissioner, in consultation with
757 the commissioner of health care finance and policy. Not later than July 1 of each year, the
758 commissioner shall by regulation establish this amount, which shall apply to contracts entered
759 into, renewed or extended on or after the following October 1. The commissioner may establish
760 different amounts for differing categories of contracts or providers, based on the factors in
761 subsection (b).

762 (b) In establishing the amount provided in subsection (a), the commissioner shall
763 consider the following factors:

764 (1) the rate of increase in the gross domestic product or consumer price index for the
765 commonwealth;

766 (2) the rate of increase in total medical expenses, as reported by the division of health
767 care finance and policy under section 6 of chapter 118G;

768 (3) a provider's rate of reimbursement with a carrier, especially in relation to the carrier's
769 statewide average relative price, as reported by the division of health care finance and policy
770 under section 6 of chapter 118G, including variability in rates where providers are above, at, or
771 below the statewide average;

772 (4) whether the carrier and a contracting provider or accountable care organization are
773 transitioning from a fee-for-service contract to an alternative payment contract; and

774 (5) other factors, consistent with the purposes of this section, that the commissioner may
775 prescribe by regulation.

776 (c) Any savings realized by the carrier from any reduction or mitigation in the growth of
777 provider prices shall be incorporated in the premiums charged to insured health plan members.

778 Section 5B. No carrier shall enter or renew a contract or agreement on or after January 1,
779 2012 with any hospital or inpatient facility with contract provisions that require the carrier to
780 contract with other health care facilities that may be affiliated with that hospital or inpatient
781 facility.

782 Section 5C. Beginning on January 1, 2014, carriers shall reduce claims payments to
783 contracting health care providers who do not file claims electronically. The amount of the
784 reduction shall be equal to the cost of processing paper claim documents above the cost of
785 processing claims electronically and shall be prominently displayed on the method of
786 reimbursement to the health care provider. The carrier shall submit a report annually by March 1
787 in a format to be determined by the commissioner pursuant to regulation that demonstrates the
788 calculation of the administrative claims payment reduction and itemizes the number of providers
789 affected by the reduction and amount of reduction in the prior calendar year.

790 Section 5D. As used in this section, terms shall have the meanings assigned by section 1
791 of chapter 118I. To facilitate the transition to the assumption of risk by ACOs, the
792 standardization across providers and payers of risk and other adjusters, and to ensure
793 transparency of payer information and protection of consumers, the division shall:

794 (a) Monitor risk arrangements between payers and ACOs in the commonwealth and, in
795 consultation with the coordinating council and the division of health care finance and policy,

796 establish any benchmarks necessary or appropriate to facilitate the transition of health care
797 providers into integrated care delivery systems that accept risk.

798 (b) Solicit the expert advice of actuaries and other risk adjustment professionals and, in
799 consultation with the coordinating council, develop methodologies for risk adjustments, risk
800 corridors, outliers, and reinsurance to protect ACOs from assuming excess risk and the
801 development of any such risk adjustment methodology shall include, but not be limited to, the
802 factors set forth in subsection (j).

803 (c) Require by regulation that all payers maintain for all members a current roster of
804 providers and ACOs available under the member's health benefit plan, and submit such rosters to
805 the division. All payers shall maintain their own websites and shall post such rosters on their
806 websites and update them at least monthly.

807 (d) Establish a nonprofit entity to be known as the Massachusetts ACO Reinsurance Plan,
808 in this subsection called the plan, as follows:

809 (1) All ACOs shall be members of the plan. The plan shall be prepared and administered
810 by a governing committee, appointed by the commissioner, consisting of 7 members representing
811 ACOs participating in the plan. The governing committee shall hire employees or contractors to
812 administer the plan.

813 (2) The governing committee shall submit to the commissioner a plan of operation and
814 the commissioner shall, after notice and hearing, approve or disapprove the plan of operation, as
815 well as the levels of reinsurance offered and levels of premiums charged to ACO members for
816 reinsurance. Subsequent amendments to the plan shall be considered approved by the

817 commissioner if not expressly disapproved in writing by the commissioner within 30 days from
818 the date of filing.

819 (3) The plan shall not reimburse an ACO with respect to the claims of a reinsured patient
820 covered under the ACO's contract in any calendar year until the ACO has paid benefits in a
821 calendar year for services otherwise covered by its contract.

822 (4) Meetings of the governing committee of the plan shall be conducted in accordance
823 with the provisions of sections 18 to 25, inclusive, of chapter 30A.

824 (5) Following the close of each fiscal year, the governing committee shall determine for
825 the next fiscal year, the premiums to be charged for reinsurance coverage, the reinsurance plan
826 expenses for administration, and the incurred losses, if any, for the prior year, taking into account
827 investment income and other appropriate gains and losses, subject to the approval of the
828 commissioner.

829 (6) Any net loss for the year shall be recouped by assessment of members. This
830 assessment shall be determined in proportion to the members' respective share of total
831 reimbursement from ACO contracts received in the prior year. The assessment charged any
832 ACO shall not exceed 5 percent of total reimbursement from ACO contracts received in the prior
833 year. If the assessment level is inadequate, the governing committee may adjust the reinsurance
834 thresholds, retention levels or consider other forms of reinsurance. (7) The governing committee
835 shall report annually to the commissioner and the joint committee on financial services about its
836 financial experience, the effect of reinsurance on the number of patients ceded and
837 recommendations, if any, on additional funding sources, if needed.

838 (8) If other funding sources are not made available, the committee may enter into
839 negotiations with plan members to resolve any deficit through reductions in future payment
840 levels. Any such recommendations shall take into account the findings of an actuarial study to
841 be undertaken within the first 3 years of the plan's operation to evaluate and measure the relative
842 risks being assumed by ACOs. The study shall be conducted by three actuaries appointed by the
843 commissioner, two of whom shall represent reinsuring ACOs and one of whom shall represent
844 the commissioner.

845 (e) Commencing January 1, 2014, in consultation with the coordinating council and the
846 division of health care finance and policy, if the division determines that risk and other
847 adjustments are not adequately standardized and consistent across all payers in the
848 commonwealth and that such standardization and consistency are necessary for containing costs
849 and improving the quality of and maintaining access to care, establish by regulation appropriate
850 standard risk adjusters which shall be utilized by all payers in the calculation of rates of payment
851 resulting from the implementation of alternative payment methods. These standard risk adjusters
852 shall include, but not be limited to, accommodation of the following factors:

- 853 1. Cost experience and efficiencies;
- 854 2. Acuity of patient case mix;
- 855 3. Clinical health status and probability of illness;
- 856 4. Socioeconomic case mix;
- 857 5. Geographic location;
- 858 6. Cultural and linguistic diversity in patient mix; and

859 7. Volume of underserved low-income patients.

860 (f) Adopt measures to ensure that its activities with respect to regulation of risk and other
861 adjustment factors do not undermine or otherwise impede the ability of consumers to have access
862 to an appropriate forum for the resolution of any grievances relating to care received through an
863 ACO. This section does not authorize the division to regulate the Medicaid program, but the
864 Medicaid program shall implement the division's regulatory standards to the extent consistent
865 with federal law.

866 (g) Have authority to adopt regulations to establish financial oversight provisions,
867 including for reserves and other financial solvency-related requirements, that shall apply to
868 ACOs and other health care providers that take on risk pursuant to an alternative payment
869 contract.

870 (h) Submit a written report annually to the coordinating council on all risk and
871 methodological evaluations performed, all findings from such evaluations, and regulations
872 promulgated pursuant to its obligations and authority under this chapter; provided, that such
873 report shall include a plan for achieving and implementing standardized risk and other
874 adjustments with payers and purchasers in the commonwealth. The coordinating council may
875 require the division to submit additional or supplemental reports or analyses.

876 (i) Participate in all meetings of the coordinating council, and participate in making
877 recommendations to other agencies represented on the coordinating council to promote the goals
878 and purposes of this section.

879 (j) Adopt or otherwise implement all recommendations made by the coordinating council
880 to the division.

881 SECTION 18. The division of insurance, in consultation with the division of health care
882 finance and policy, shall conduct a study of the effects of section 5A of chapter 176O of the
883 General Laws. The study shall include, but not be limited to, an examination of the impact on
884 carrier provider networks, network adequacy, rates paid to non-participating providers, and the
885 overall impact on carrier member premiums. The division shall file a report, with its findings
886 and any recommendations for legislation, with the coordinating council established by chapter
887 118I of the General Laws and with the clerks of the senate and house of representatives not later
888 than January 1, 2014.

889 Clinician-Patient Communication and Grievance Resolution

890 SECTION 19. Chapter 231 of the General Laws is hereby amended by inserting after
891 section 60K the following section:-

892 Section 60L. (a). Except as provided in this section, a person shall not commence an
893 action against a provider of health care as defined in the seventh paragraph of section 60B unless
894 the person has given the health care provider written notice under this section of not less than
895 180 days before the action is commenced.

896 (b) The notice of intent to file a claim required under subsection (a) shall be mailed to
897 the last known professional business address or residential address of the health care provider
898 who is the subject of the claim.

899 (c) The 180 day notice period in subsection (a) is shortened to 90 days if all of the
900 following conditions exist:

901 (1) The claimant has previously filed the 180-day notice required in subsection (a)
902 against another health care provider involved in the claim.

903 (2) The 180-day notice period has expired as to the health care providers described in
904 clause (1).

905 (3) The claimant has filed a complaint and commenced an action alleging medical
906 malpractice against one or more of the health care providers described in clause (1).

907 (4) The claimant did not identify and could not have reasonably have identified a health
908 care provider to which notice must be sent under subsection (a) as a potential party to the action
909 before filing the complaint.

910 (d) The notice given to a health care provider under this section shall contain a statement
911 of at least all of the following:

912 (1) The factual basis for the claim.

913 (2) The applicable standard of care alleged by the claimant.

914 (3) The manner in which it is claimed that the applicable standard of care was breached
915 by the health care provider.

916 (4) The alleged action that should have been taken to achieve compliance with the alleged
917 standard of care.

918 (5) The manner in which it is alleged the breach of the standard of care was the proximate
919 cause of the injury claimed in the notice.

920 (6) The names of all health care providers the claimant is notifying under this section in
921 relation to the claim.

922 (e) Not later than 30 days after giving notice under this section, the claimant shall allow
923 the health care provider receiving the notice access to all of the medical records related to the
924 claim that are in the claimant's control, and shall furnish release for any medical records related
925 to the claim that are not in the claimant's control, but of which the claimant has knowledge. This
926 subsection does not restrict a health care provider receiving notice under this section from
927 communicating with other health care providers and acquiring medical records as permitted
928 under any other provision of law. This subsection does not restrict a patient's right of access to
929 the patient's medical records under any other law.

930 (f) Within 90 days after receipt of notice under this section, the health care provider
931 against whom the claim is made shall furnish to the claimant or his or her authorized
932 representative a written response that contains a statement of each of the following:

933 (1) The factual basis for the defense to the claim.

934 (2) The standard of care that the health care provider claims to be applicable to the action
935 and that the health care provider complied with that standard.

936 (3) The manner in which it is claimed by the health care provider that there was
937 compliance with the applicable standard of care.

938 (4) The manner in which the health care provider contends that the alleged negligence of
939 the health care provider was not the proximate cause of the claimant's alleged injury or alleged
940 damage.

941 (g) Within 90 days after receipt of notice under this section, the health care provider
942 against whom the claim is made shall furnish the claimant all medical records and other
943 documents related to the claim that are in the provider's control.

944 (h) If the claimant does not receive the written response required under subsection (f)
945 within the required 90-day time period, the claimant may commence an action alleging medical
946 malpractice upon the expiration of the 90-day period.

947 (i) If at any time during the applicable notice period under this section a health care
948 provider receiving notice under this section informs the claimant in writing that the health care
949 provider does not intend to settle the claims within the applicable notice period, the claimant may
950 commence an action alleging medical malpractice against the health care provider.

951 (j) If the claimant does not have knowledge or notice of his injury and could not
952 reasonably have determined the existence of injury until a time in which compliance with this
953 section would render a claim based on such injury barred by the statute of limitations, then the
954 statute of limitations shall be tolled for a sufficient amount of time to allow for compliance with
955 this section before commencing an action against a health care provider.

956 Treatment of Provider Apology in Litigation

957 SECTION 20. Chapter 233 of the General Laws is hereby amended by inserting after
958 section 79K the following section:-

959 Section 79L. (a) As used in this section, the following terms shall have the following
960 meaning:

961 “Health care provider”, any of the following health care professionals licensed pursuant to
962 chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist,
963 optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social
964 worker, speech-language pathologist, audiologist, marriage and family therapist and a mental
965 health counselor. The term shall also include any corporation, professional corporation,
966 partnership, limited liability company, limited liability partnership, authority, or other entity
967 comprised of such health care providers.

968 “Facility”, a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home
969 health agency. The term shall also include any corporation, professional corporation,
970 partnership, limited liability company, limited liability partnership, authority, or other entity
971 comprised of such facilities.

972 “Unanticipated outcome” means the outcome of a medical treatment or procedure,
973 whether or not resulting from an intentional act, that differs from an intended result of such
974 medical treatment or procedure.

975 (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly
976 experiencing an unanticipated outcome of medical care, statements, affirmations, gestures,
977 activities or conduct expressing benevolence, regret, apology, sympathy, commiseration,
978 condolence, compassion, mistake, error, or a general sense of concern which are made by a
979 health care provider, facility or an employee or agent of a health care provider or facility, to the
980 patient, a relative of the patient, or a representative of the patient and which relate to the
981 unanticipated outcome shall be inadmissible as evidence in any judicial or administrative
982 proceeding and shall not constitute an admission of liability or an admission against interest.

983 Duties of the Executive Office of Health and Human Services

984 SECTION 21. As used in this section, terms shall have the meanings assigned by section
985 1 of chapter 118I of the General Laws. To promote the adoption of alternative payment
986 methodologies and contracting with ACOs by both private and public purchasers of health care,
987 the executive office of health and human services shall:

988 (a) Seek to obtain a federal waiver of statutory provisions necessary to permit
989 Medicare to participate in the commonwealth's alternative payment methods. Upon obtaining
990 federal approval for Medicare participation, such participation shall be commenced and
991 continued and the executive office shall seek extensions or additional approvals, as necessary.

992 (b) By August 15, 2011, request and seek to obtain from the federal office of the
993 inspector general by the following:

994 1) a waiver of the provisions of, or expansion of the "safe harbors" to, 42 U.S.C.
995 section 1320a-7b and implementing regulations or any other necessary authorization the
996 coordinating council determines may be necessary to permit certain shared risk and other risk
997 sharing arrangements among providers and ACOs; and

998 2) a waiver of or exemption from the provisions of 42 U.S.C. section 1395nn(a) to
999 (e) and implementing regulations or other necessary authorization the coordinating council
1000 determines may be necessary to permit physician referrals to other providers as needed to
1001 support the transition to and implementation of global and alternative payment systems and
1002 formation of ACOs.

1003 (c) Facilitate coordination of the use of alternative payment methodologies and
1004 contracting with ACOs across all state entities. The executive office of health and human
1005 services shall take the lead in negotiations with the Centers for Medicare and Medicaid services
1006 in contracts for reimbursement for Medicare services under this chapter.

1007 (d) (1) Develop a pilot program with one or more health systems that are early adopters
1008 of the ACO model under chapter 118I of the General Laws, provided it determines that doing so
1009 will not conflict with other pilot programs it may be pursuing or engaged in. The pilot program
1010 shall provide quality improvement incentive grants to selected health systems which establish
1011 and participate in a cooperative effort between representatives of employees and management
1012 that is focused on controlling costs and improving the quality of care. These piloted labor-
1013 management partnership efforts shall implement an employee education/training program and
1014 other needed initiatives in order to achieve the following goals:

1015 (i) Engage the health systems' workforce in efforts to implement the necessary system
1016 reforms needed to move from a fee-for-service to a global payments model;

1017 (ii) Engage the health systems' workforce in efforts to measurably improve the quality of
1018 care provided by the health system, to reduce medical errors and to decrease unnecessary health
1019 care utilization; and

1020 (iii) Engage the health system's workforce in efforts to prepare the health system to
1021 comply with all MassHealth pay-for-performance standards and new MassHealth policies on
1022 non-payment for certain identified serious reportable events; and

1023 (iv) Develop team-based care delivery systems that integrate the work of management,
1024 physicians and the entire health care workforce to address systemic issues and implement
1025 innovative solutions designed to reduce costs and improve the quality of care delivery.

1026 (2) Upon completion of the pilot grant program described in paragraph (1), the executive
1027 office shall prepare a comprehensive report on the pilot program which offers legislative,
1028 regulatory and other recommendations to establish new and permanent labor-management
1029 quality incentive payment initiatives. This report shall include recommendations whether to:

1030 (i) Create a new and permanent MassHealth quality improvement incentive payment
1031 system to promote cooperative labor-management efforts; and

1032 (ii) Expand the new MassHealth incentive payment system to all health systems; and

1033 (iii) Develop additional quality incentive payment systems through modifications of
1034 private insurance carriers' provider reimbursement payment methods that are designed to
1035 incentivize cooperative labor-management efforts.

1036 (3) The executive office shall seek federal and other financial support to supplement state
1037 resources to carry out this clause (d).

1038 (4) The executive office shall adopt regulations or procedures to carry out this clause (d).

1039 (e) Submit a written report annually to the coordinating council on all of its waiver,
1040 coordination and negotiation obligations, and regulations promulgated pursuant to its obligations
1041 and authority under this chapter. This report shall include a plan for achieving all milestones and
1042 benchmarks relating to the transition to the ACO model of care and adoption of alternative
1043 payment methodologies by purchasers, payers, and providers of publicly funded services. The

1044 executive office shall submit additional or supplemental reports or analyses at the request of the
1045 coordinating council.

1046 (f) Participate in all meetings of the coordinating council, and shall participate in making
1047 recommendations to other agencies represented on the coordinating council as needed to promote
1048 the goals and purposes of this act. The secretary of health and human services shall adopt or
1049 otherwise implement all recommendations made by the coordinating council to the executive
1050 office of health and human services to the extent consistent with federal law.

1051 Behavioral Health Care Task Force

1052 SECTION 22. There shall be a task force comprised of 9 representatives with expertise
1053 in behavioral health treatment, service delivery, integration of behavioral health with primary
1054 care, and behavioral health reimbursement systems. The coordinating council shall appoint the
1055 members of the task force. The task force shall report to the coordinating council its findings
1056 and recommendations relative to (a) the most effective and appropriate approach to including
1057 behavioral health services in the array of services provided by ACOs; (b) how current prevailing
1058 reimbursement methods and covered behavioral health benefits may need to be modified to
1059 achieve more cost effective, integrated and high quality behavioral health outcomes; and (c) the
1060 extent to which and how payment for behavioral health services should be included under
1061 alternative payment methods established or regulated under this act. The first meeting shall be
1062 convened within 60 days after passage of this act. The task force shall submit its report of
1063 findings and recommendations to the coordinating council no later than April 1, 2013.