

**SENATE . . . . . No. 02270**

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

## The Commonwealth of Massachusetts

## **In the Year Two Thousand Twelve**

An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation..

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

1 SECTION 1. Section 38C of chapter 3 of the General Laws, as appearing in the 2010  
2 Official Edition, is hereby amended by striking out, in lines 25, 29, 32, 35, 37, 39, 40, 44 and 45,  
3 47, 48, 54, 86, 89 and 93, the word “division” and inserting in place thereof, in each instance,  
4 the following word:- institute.

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

8 SECTION 3. Section 105 of chapter 6 of the General Laws , as amended by section 9 of  
9 chapter 3 of the acts of 2011, is hereby further amended by striking out the words “commissioner

10 of health care finance and policy" and inserting in place thereof the following words:- executive  
11 director of the institute of health care finance and policy.

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

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17 hereby repealed.

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

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

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

28 SECTION 9. Section 16N of said chapter 6A, as so appearing, is hereby amended by  
29 striking out, in lines 5 and 6, the words "commissioner of health care finance and policy" and

30 inserting in place thereof the following words:- executive director of the institute of health care  
31 finance and policy.

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

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

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

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

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

52 chapter 12C and section 6 of chapter 176S, and subject to the limitations stated in those sections,  
53 the attorney general may require that any provider, provider organization, private health care  
54 payer or public health care payer produce documents, answer interrogatories and provide  
55 testimony under oath related to health care costs and cost trends , the factors that contribute to  
56 cost growth within the commonwealth's health care system and the relationship between  
57 provider costs and payer premium rates.

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

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

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

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

75 Chapter 12C

76 Institute of Health Care Finance and Policy

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

79 "Actual costs", all direct and indirect costs incurred by a hospital or a community health  
80 center in providing medically necessary care and treatment to its patients, determined in  
81 accordance with generally accepted accounting principles.

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

86           “Alternative payment contract”, any contract between a provider or provider organization  
87 and a public health care payer or a private health care payer which utilizes alternative payment  
88 methodologies.

89        “Alternative payment methodologies”, methods of payment that are not fee-for-service  
90  reimbursements; provided that, “alternative payment methodologies” may include, but not be  
91  limited to, global payments, shared savings arrangements, bundled payments and episodic  
92  payments.

93        “Ambulatory surgical center”, any distinct entity that operates exclusively to provide  
94    surgical services to patients not requiring hospitalization and meets the requirements of the  
95    federal Health Care Financing Administration for participation in the Medicare program.

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

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

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

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

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

114        “Clinical affiliation,” any relationship between a provider organization and another entity  
115    for the purpose of increasing the level of collaboration in the provision of health care services,  
116    including but not limited to sharing of physician resources in hospital or other ambulatory  
117    settings, co-branding, expedited transfers to advanced care settings, provision of inpatient  
118    consultation coverage or call coverage, enhanced electronic access and communication, co-  
119    located services, provision of capital for service site development, joint training programs, video  
120    technology to increase access to expert resources and sharing of hospitalists or intensivists.

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

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

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

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

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

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

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

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

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

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

152        "General health supplies, care or rehabilitative services and accommodations", all  
153        supplies, care and services of medical, behavioral health, substance use disorder, mental health,  
154        optometric, dental, surgical, chiropractic, podiatric, psychiatric, therapeutic, diagnostic,  
155        rehabilitative, supportive or geriatric nature, including inpatient and outpatient hospital care and

156 services, and accommodations in hospitals, sanatoria, infirmaries, convalescent and nursing  
157 homes, retirement homes, facilities established, licensed or approved under chapter 111B and  
158 providing services of a medical or health-related nature, and similar institutions including those  
159 providing treatment, training, instruction and care of children and adults; provided, however, that  
160 rehabilitative service shall include only rehabilitative services of a medical or health-related  
161 nature which are eligible for reimbursement under Title XIX of the Social Security Act.

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

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

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

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

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

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

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

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

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

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

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

195        “Major service category,” a set of service categories to be established by regulation,  
196 which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii)  
197 outpatient and ambulatory services, by categories as defined by the Centers for Medicare and

198 Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all  
199 other” outpatient and ambulatory services that do not fall within a defined category; (iii)  
200 behavioral, substance use disorder and mental health services by categories as defined by the  
201 Centers for Medicare and Medicaid, or as established by regulation; (iv) professional services, by  
202 categories as defined by the Centers for Medicare and Medicaid, or as established by regulation;  
203 and (v) sub-acute services, by major service line or clinical offering, as defined by regulation.

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

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

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

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

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

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

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

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

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

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

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

236       “Provider organization,” any corporation, partnership, business trust, association or  
237 organized group of persons whether incorporated or not that consists of or represents 1 or more  
238 providers in contracting with carriers for the payments the provider or providers receive for the  
239 provision of health care services or as defined in regulations promulgated by the institute;

240 provided, that “provider organization” shall include, but not be limited to, physician  
241 organizations, physician-hospital organizations, independent practice associations, provider  
242 networks, accountable care organizations and any other organization that contracts with carriers  
243 for payment for health care services.

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

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

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

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

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

262       “Resident”, a person living in the commonwealth, as defined by the institute by  
263 regulation; provided, however, that such regulation shall not define a resident as a person who  
264 moved into the commonwealth for the sole purpose of securing health insurance under this  
265 chapter; and provided, further that confinement of a person in a nursing home, hospital or other  
266 medical institution shall not in and of itself, suffice to qualify such person as a resident.

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

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

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

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

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

284 programs of public assistance and their beneficiaries or recipients and the workers' compensation  
285 program established under chapter 152.

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

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

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

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

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

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

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

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

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

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

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

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

352   the following powers:—

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

354                   (b) to make contracts and execute all instruments necessary or convenient for the carrying

355   on of its business;

356                   (c) to acquire, own, hold, dispose of and encumber personal property and to lease real

357   property in the exercise of its powers and the performance of its duties; and

358                   (d) to enter into agreements or transactions with any federal, state or municipal agency or

359   other public institution or with any private individual, partnership, firm, corporation, association

360   or other entity.

361                   Section 8. Each acute hospital and surcharge payor shall pay to the commonwealth an

362   amount for the estimated expenses of the institute.

363                   The assessed amount for hospitals shall be not less than 33 per cent of the amount

364   appropriated by the general court for the expenses of the institute minus amounts collected from

365   (1) filing fees; (2) fees and charges generated by the institute's publication or dissemination of

366   reports and information; and (3) federal matching revenues received for these expenses or

367   received retroactively for expenses of predecessor agencies. Each acute hospital shall pay such

368   assessed amount multiplied by the ratio of the hospital's gross patient service revenues to the

369   total of all such hospital's gross patient services revenues. Each acute hospital shall make a

370   preliminary payment to the institute on October 1 of each year in an amount equal to  $\frac{1}{2}$  of the

371   previous year's total assessment. Thereafter, each hospital shall pay, within 30 days notice from

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1049           (i) support the development and implementation of employer and work programs  
1050 to enhance worker skills, income, productivity and retention rates;  
1051           (ii) address critical workforce shortages;  
1052           (iii) address workforce needs identified in the health resource plan developed  
1053 under section 25A of chapter 111;  
1054           (iv) improve employment in the health care industry for the unemployed or low-  
1055 income individuals and low-wage workers;

1056 (v) provide training or educational services for currently employed or unemployed

1057 health care workers who are seeking new positions or responsibilities within the health care

1058 industry;

1059 (vi) provide training or educational services for existing health care workers in

1060 emerging fields of care delivery models;

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

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

1063 (ix) any other purpose the secretary, in consultation with the Health Care

1064 Workforce Advisory Board, determines.

1065 (e) The secretary shall establish a competitive grant process funded by the Health Care

1066 Workforce Transformation Fund to eligible applicants to provide education and training to health

1067 care workers. Eligible applicants shall include: employers and employer associations; local

1068 workforce investment boards; labor organizations; joint labor-management partnerships;

1069 community-based organizations; institutions of higher education; vocational education

1070 institutions; one-stop career centers; local workforce development entities; and any partnership

1071 or collaboration between eligible applicants. Expenditures from the fund for such purposes shall

1072 complement and not replace existing local, state, private, or federal funding for training and

1073 educational programs.

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

1075 (i) a plan that defines specific goals for health care workforce training and

1076 educational improvements over a multi-year period in specific areas;

1077 (ii) the evidence-based programs the applicant shall use to meet the goals;

1078 (iii) a budget necessary to implement the plan, including a detailed description of

1079 any funding or in-kind contributions the applicant or applicants will be providing in support of

1080 the proposal;

1081 (iv) any other private funding or private sector participation the applicant

1082 anticipates in support of the proposal; and

1083 (v) the anticipated number of individuals who would receive a benefit due to the

1084 implementation of the plan.

1085 Priority may be given to proposals that target areas of critical labor needs for the health

1086 care industry or that are projected to be critical labor needs of the health care industry in the near

1087 future. Priority may also be given to proposals that target geographic areas with specific health

1088 care workforce needs or that target geographic areas with unemployment levels higher than the

1089 state average. If no proposals were offered in areas of particular need, the secretary may

1090 provide technical assistance and planning grant funding directly to eligible applicants in order to

1091 develop grant proposals.

1092 The secretary shall, in consultation with the Health Care Workforce Advisory Board,

1093 develop guidelines for an annual review of the progress being made by each grantee. Each

1094 grantee shall participate in any evaluation or accountability process implemented by or

1095 authorized by the secretary.

1096 (g) The secretary shall annually expend not less than 20 per cent of available funds in the

1097 Health Care Workforce Transformation Fund to expand training and loan forgiveness programs

1098 for primary care providers in the commonwealth. The training and loan forgiveness programs

1099 for primary care providers shall include, but not be limited to:

1100 (i) The secretary shall establish a competitive primary care residency grant process funded by the

1101 Health Care Workforce Transformation Fund to eligible applicants for the purpose of financing

1102 the training of primary care providers at teaching community health centers. Eligible applicants

1103 shall include teaching community health centers accredited through affiliations with a

1104 commonwealth funded medical school or licensed as part of a teaching hospital with a residency

1105 program in primary care or family medicine and teaching health centers that are the

1106 independently accredited sponsoring organization for the residency program and whose residents

1107 are employed by the health center.

1108 To receive funding, an applicant shall (a) include a review of recent graduates of the teaching

1109 community health center's residency program, including information regarding what type of

1110 practice said graduates are involved in 2 years following graduation from the residency program;

1111 and (b) achieve a threshold of at least 50 per cent for the percentage of graduates practicing

1112 primary care within 2 years after graduation. Graduates practicing (a) more than 50 per cent

1113 inpatient care or (b) more than 50 per cent specialty care, as listed in the American Medical

1114 Association Masterfile, shall not qualify as graduates practicing primary care.

1115 Awardees of the primary care residency grant program shall maintain their teaching accreditation

1116 as either an independent teaching community health center or as a teaching community health

1117 center accredited through affiliation with a commonwealth funded medical school or licensed as

1118 part of a teaching hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1185 shall be from a physician group practice, 1 of whom shall be a non-physician health care  
1186 provider, 1 of whom shall be a registered nurse, 1 of whom shall be a member from a behavioral  
1187 health, substance abuse disorder or mental health services organization and 2 of whom shall  
1188 represent the health insurance carriers. The council may consult with such parties, public or  
1189 private, as it deems desirable in exercising its duties under this section, including persons with  
1190 expertise and experience in the development and dissemination of interoperable electronic health  
1191 records systems and the implementation of interoperable electronic health record systems by  
1192 small physician groups or ambulatory care providers as well as persons representing  
1193 organizations within the commonwealth interested in and affected by the development of  
1194 networks and interoperable electronic health records systems, including, but not limited to,  
1195 persons representing local public health agencies, licensed hospitals and other licensed facilities  
1196 and providers, private purchasers, community-based behavioral providers, substance use disorder  
1197 and mental health care providers, the medical and nursing professions, physicians, health  
1198 insurers and health plans, the state quality improvement organization, academic and research  
1199 institutions, consumer advisory organizations with expertise in health information technology  
1200 and other stakeholders as identified by the secretary of health and human services. Appointive  
1201 members of the council shall serve for terms of 2 years or until a successor is appointed.  
1202 Members shall be eligible to be reappointed and shall serve without compensation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1344 (h) The council shall receive staff assistance from the corporation.  
1345 (i) The institute shall file an annual report, not later than January 30, with the joint  
1346 committee on health care financing, the joint committee on economic development and emerging  
1347 technologies and the house and senate committees on ways and means concerning the activities  
1348 of the council in general and, in particular, describing the progress to date in implementing a  
1349 statewide interoperable electronic health records system and recommending such further  
1350 legislative action as it deems appropriate.

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

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

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

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

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

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

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

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

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

1403 a person who received free care services paid for in whole or in part by the Health Safety Net

1404 Trust Fund or on whose behalf said fund paid for emergency bad debt.

1405 SECTION 37. Said section 1 of said chapter 62D, as so amended, is hereby further

1406 amended by striking out, in line 55, the words “section 39 of chapter 118G” and inserting in

1407 place thereof the following words:- section 69 of chapter 118E.

1408 SECTION 38. Section 8 of said chapter 62D, as appearing in the 2010 Official Edition, is

1409 hereby amended by striking out the second paragraph.

1410 SECTION 39. Section 10 of said chapter 62D, as so appearing, is hereby amended by

1411 striking out, in lines 8 and 9, the words “the division of medical assistance, the corporation, the

1412 office of the state comptroller, and the division of health care finance and policy” and inserting

1413 in place thereof the following words:- the office of medicaid, the corporation, the office of the

1414 state comptroller and the executive office of health and human services.

1415 SECTION 40. Section 13 of said chapter 62D, as amended by section 14 of chapter 142

1416 of the acts of 2011, is hereby further amended by striking out the words “section 39 of chapter

1417 118G” and inserting in place thereof the following words:- section 69 of chapter 118E.

1418 SECTION 41. Section 3 of chapter 62E of the General Laws, as appearing in the 2010

1419 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words “division of

1420 health care finance and policy” and inserting in place thereof the following words:- executive

1421 office of health and human services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1675 Section 25C. (a) Notwithstanding any general or special law to the contrary, except as  
1676 provided in section 25 C $\frac{1}{2}$ , no person or agency of the commonwealth or any political  
1677 subdivision thereof shall make substantial capital expenditures for construction of a health care  
1678 facility or substantially change the service of such facility unless there is a determination by the  
1679 department that there is need for such construction or change. No such determination of need  
1680 shall be required for any substantial capital expenditure for construction or any substantial  
1681 change in service which shall be related solely to the conduct of research in the basic biomedical

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

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

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

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

1711 (d) No person or agency of the commonwealth or any political subdivision thereof shall  
1712 acquire for location in other than a health care facility a unit of medical, diagnostic, or  
1713 therapeutic equipment, other than equipment used to provide an innovative service or which is a  
1714 new technology, with a fair market value in excess of \$150,000 unless the person or agency  
1715 notifies the department of the person's or agency's intent to acquire such equipment and of the  
1716 use that will be made of the equipment. Such notice shall be made in writing and shall be  
1717 received by the department at least 30 days before contractual arrangements are entered into to  
1718 acquire the equipment with respect to which notice is given. A determination by the department  
1719 of need for such equipment shall be required for any such acquisition (i) if the notice required by  
1720 this subsection is not filed in accordance with the requirements of this subsection; and (ii) if the  
1721 requirements for exemption under subsection (a) of section 25 C $\frac{1}{2}$  are not met; provided,  
1722 however, that in no event shall any person who acquires a unit of magnetic resonance imaging  
1723 equipment for location other than in a health care facility refer or influence any referrals of  
1724 patients to said equipment, unless said person is a physician directly providing services with that  
1725 equipment; provided, however, that for the purposes of this section, no public advertisement  
1726 shall be deemed a referral or an influence of referrals; and provided, further, that any person who

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

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

1732 (f) Except as provided in section 25 C $\frac{1}{2}$ , no person or agency of the commonwealth or  
1733 any political subdivision thereof shall acquire an existing health care facility unless the person or  
1734 agency notifies the department of the person's or agency's intent to acquire such facility and of  
1735 the services to be offered in the facility and its bed capacity. Such notice shall be made in writing  
1736 and shall be received by the department at least 30 days before contractual arrangements are  
1737 entered into to acquire the facility with respect to which the notice is given. A determination of  
1738 need shall be required for any such acquisition if the notice required by this subsection is not  
1739 filed in accordance with the requirements of this subsection or if the department finds, within 30  
1740 days after receipt of notice under this subsection, that the services or bed capacity of the facility  
1741 will be changed in being acquired.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1860 (b) The center shall communicate and coordinate with the institute for health care finance and  
1861 policy, the health care quality and finance authority, the secretary of labor and workforce  
1862 development, and the health disparities council, established by section 16O of said chapter 6A.

1863 (c) The center shall annually submit a report, not later than March 1, to the governor; and

1864 the general court, by filing the report with the clerks of the house of representatives and the

1865 senate, the joint committee on labor and workforce development, the joint committee on health

1866 care financing and the joint committee on public health. The report shall include: (i) data on

1867 patient access and regional disparities in access to physicians, by specialty and sub-specialty,

1868 behavioral, substance use disorder and mental health professionals and nurses; (ii) data on factors

1869 influencing recruitment and retention of physicians, nurses and behavioral, substance use

1870 disorder and mental health professionals; (iii) short and long-term projections of physicians,

1871 nurses and behavioral, substance use disorder and mental health professionals supply and

1872 demand; (iv) strategies being employed by the council or other entities to address workforce

1873 needs, shortages, recruitment and retention; (v) recommendations for designing, implementing

1874 and improving programs or policies to address workforce needs, shortages, recruitment and

1875 retention; and (vi) proposals for statutory or regulatory changes to address workforce needs,

1876 shortages, recruitment and retention.

1877 SECTION 54. Said chapter 111 is hereby further amended by striking out sections 25M

1878 and 25N, as appearing in the 2010 Official Edition, and inserting in place thereof the following 2

1879 sections:-

1880 Section 25M. (a) There shall be a healthcare provider workforce advisory council within,

1881 but not subject to the control of, the health care provider workforce center established by section

1882 25L. The council shall advise the center on the capacity of the healthcare workforce to provide

1883 timely, effective, culturally competent, quality physician, nursing and behavioral, substance use

1884 disorder and mental health services.

1885 (b) The council shall consist of 19 members, 1 of whom shall be the commissioner of  
1886 public health, who shall serve as chair; 3 of whom shall be appointed by the governor: 1 of  
1887 whom shall be a physician with a primary care specialty designation; 1 of whom shall be an  
1888 advanced practice nurse, authorized under section 80B of said chapter 112; 1 of whom shall be a  
1889 behavioral, substance use disorder and mental health professional; and 1 person from each of the  
1890 following organizations who shall be appointed by the secretary of health and human services  
1891 from a list of nominees submitted by the organization: the Association for Behavioral  
1892 Healthcare; the Massachusetts Psychiatric Society; the Massachusetts Psychological Association;  
1893 the National Association of Social Workers Massachusetts Chapter; the Massachusetts Extended  
1894 Care Federation; the Organization of Nurse Leaders; the Massachusetts Academy of Family  
1895 Physicians; the Massachusetts League of Community Health Centers, Inc.; the Massachusetts  
1896 Medical Society; the Massachusetts Nurses Association; the Massachusetts Association of  
1897 Physician Assistants; the Massachusetts Association of Registered Nurses; the Massachusetts  
1898 Hospital Association, Inc.; the Massachusetts Chiropractic Society, Inc.; and Health Care For  
1899 All, Inc. Members of the council shall be appointed for a term of 3 years or until a successor is  
1900 appointed. Members shall be eligible to be reappointed and shall serve without compensation,  
1901 but may be reimbursed for actual and necessary expenses reasonably incurred in the performance  
1902 of their duties. Vacancies of unexpired terms shall be filled within 60 days by the appropriate  
1903 appointing authority.

1904 The council shall meet at least bimonthly, at other times as determined by its rules and  
1905 when requested by any 8 members.

1906 (c) The council shall advise the center on: (i) trends in access to primary care and  
1907 physician subspecialties, nursing and behavioral, substance use disorder and mental health

1908 services; (ii) the development and administration of the loan repayment program, established  
1909 under section 25N, including criteria to identify underserved areas in the commonwealth; (iii)  
1910 solutions to address identified health care workforces shortages; and (iv) the center's annual  
1911 report to the general court.

1912                   Section 25N. (a) There shall be a health care provider workforce loan repayment  
1913 program, administered by the health care provider workforce center established by section 25L.  
1914 The program shall provide repayment assistance for undergraduate, graduate and medical school  
1915 loans to participants who: (i) are graduates of medical or nursing schools or accredited colleges,  
1916 universities or graduate schools; (ii) specialize in family health or medicine, internal medicine,  
1917 pediatrics, psychiatry, obstetrics/gynecology, behavioral health, mental health or substance use  
1918 disorder treatment; (iii) demonstrate competency in health information technology, including use  
1919 of electronic medical records, computerized physician order entry and e-prescribing; and (iv)  
1920 meet other eligibility criteria, including service requirements, established by the board. Each  
1921 recipient shall be required to enter into a contract with the commonwealth which shall obligate  
1922 the recipient to perform a term of service of not less than 2 years in medically underserved areas  
1923 as determined by the center.

1924                   (b) The center shall promulgate regulations for the administration and enforcement of this  
1925 section which shall include penalties and repayment procedures if a participant fails to comply  
1926 with the service contract.

1927                   The center shall, in consultation with the health care workforce advisory council and the  
1928 public health council, establish criteria to identify medically underserved areas within the  
1929 commonwealth. These criteria shall consist of quantifiable measures, which may include the

1930 availability of primary care medical services or behavioral, substance use disorder and mental  
1931 health services within reasonable traveling distance, poverty levels and disparities in health care  
1932 access or health outcomes.

1933 (c) The center shall evaluate the program annually, including exit interviews of  
1934 participants to determine their post-program service plans and to solicit program improvement  
1935 recommendations.

1936 (d) The center shall file an annual report, not later than July 1, with the governor, the  
1937 clerks of the house of representatives and the senate, the house and senate committees on ways  
1938 and means, the joint committee on health care financing, the joint committee on mental health  
1939 and substance abuse and the joint committee on public health. The report shall include annual  
1940 data and historical trends of: (i) the number of applicants, the number accepted and the number  
1941 of participants by race, gender, medical or nursing specialty, medical or nursing school,  
1942 residence prior to medical or nursing school and where they plan to practice after program  
1943 completion; (ii) the service placement locations and length of service commitments by  
1944 participants; (iii) the number of participants who fail to fulfill the program requirements and the  
1945 reason for the failures; (iv) the number of former participants who continue to serve in  
1946 underserved areas; and (v) program expenditures.

1947 SECTION 55. Section 51 of said chapter 111, as so appearing, is hereby amended by  
1948 striking out, in lines 25 and 26, the words "division of health care finance and policy" and  
1949 inserting in place thereof the following words:- commonwealth health insurance connector.

1950 SECTION 56. Said section 51 of said chapter 111, as so appearing, is hereby further

1951 amended by striking out, in lines 25, 36 and 46, the word “division” and inserting in place

1952 thereof, in each instance, the following word:- institute.

1953 SECTION 57. Said section 51 of said chapter 111, as so appearing, is hereby further

1954 amended by striking out, in lines 27 and 28, the words “pursuant to section 18 of chapter 118G”.

1955 SECTION 58. Section 51G of said chapter 111, as so appearing, is hereby amended by

1956 inserting after the words “or services,”, in line 38, the following words:- conduct a public hearing

1957 on the closure of said essential services or of the hospital. The department shall.

1958 SECTION 59. Subsection (c) of section 51H of said chapter 111, as so appearing, is

1959 hereby amended by striking out, in lines 70 and 71, the words “and to the health care quality and

1960 cost council”.

1961 SECTION 60. Said chapter 111 is hereby further amended by inserting after section 51H

1962 the following 2 sections:-

1963 Section 51I. (a) As used in this section the following words shall, unless the context

1964 clearly requires otherwise, have the following meanings:-

1965 “Adverse event”, injury to a patient resulting from a medical intervention, and not to the

1966 underlying condition of the patient.

1967 “Checklist of care”, pre-determined steps to be followed by a team of healthcare

1968 providers before, during and after a given procedure to decrease the possibility of patient harm

1969 by standardizing care.

1970        "Facility," a hospital, institution maintaining an Intensive Care Unit, institution providing  
1971    surgical services or clinic providing ambulatory surgery.

1972        (b) The department shall encourage the development and implementation of checklists of  
1973    care that prevent adverse events and reduce healthcare-associated infection rates. The department  
1974    shall develop model checklists of care, which may be implemented by facilities; provided  
1975    however, that facilities may develop and implement checklists independently.

1976        (c) Facilities shall report data and information relative to their use or non-use of  
1977    checklists to the department and the Betsy Lehman center for patient safety and medical error  
1978    reduction. The department may consider facilities that use similar programs to be in compliance.  
1979    The department shall publicly report on individual hospitals' compliance rates.. Individual  
1980    reports shall be kept confidential by the department and the Betsy Lehman center, but aggregated  
1981    compliance rates shall be posted publicly.

1982        Section 51J. The department shall promulgate regulations regarding limited services  
1983    clinics. The regulations shall promote the availability of limited services clinics as a point of  
1984    access for health care services within the full scope of practice of a nurse practitioner or other  
1985    clinician providing services.

1986        SECTION 60A. Section 52 of said chapter 111, as so appearing, is hereby amended by  
1987    inserting, after the definition of "Institution for unwed mothers" the following 2 definitions:-  
1988    "Limited services", diagnosis, treatment, management and monitoring of acute and chronic  
1989    disease, wellness and preventative services of a nature that may be provided within the scope of  
1990    practice of a nurse practitioner or other clinician providing services using available facilities and  
1991    equipment, including shared toilet facilities for point-of-care testing.

1992       “Limited services clinic”, a clinic that provides limited services.

1993       SECTION 61. Said chapter 111 is hereby further amended by inserting, after section  
1994 53G, the following section:-

1995       Section 53H. No hospital shall enter into a contract or agreement, which creates or  
1996 establishes a partnership, employment or any other professional relationship with a licensed  
1997 physician that would prohibit or limit the ability of said physician to provide testimony in an  
1998 administrative or judicial hearing, including cases of medical malpractice.

1999       SECTION 62. Section 62M of said chapter 111, as so appearing, is hereby amended by  
2000 striking out, in line 13, the words “division of health care finance and policy” and inserting in  
2001 place thereof the following words:- executive office of health and human services or a  
2002 governmental unit designated by the executive office.

2003       SECTION 63. Section 67C of said chapter 111, as so appearing, is hereby amended by  
2004 striking out, in line 8, the words “division of health care finance and policy” and inserting in  
2005 place thereof the following words:- executive office of health and human services.

2006       SECTION 64. Section 69H of said chapter 111, as so appearing, is hereby amended by  
2007 striking out, in lines 2 and 3, the words “division of health care finance and policy” and inserting  
2008 in place thereof the following words:- executive office of health and human services or a  
2009 governmental unit designated by the executive office.

2010       SECTION 64A. Said chapter 111, as so appearing, is hereby amended by inserting after  
2011 section 70G the following section:-

2012                   Section 70H. Notwithstanding chapter 93A, sections 70E, 72E and 73 and 940 CMR

2013   section 4.09, a facility or institution licensed by the department of public health under section 71

2014   may move a resident to different living quarters or to a different room within the facility or

2015   institution if, as documented in the resident's clinical record and as certified by a physician, the

2016   resident's clinical needs have changed such that the resident either (1) requires specialized

2017   accommodations, care, services, technologies, staffing not customarily provided in connection

2018   with the resident's living quarters or room, or (2) ceases to require the specialized

2019   accommodations, care, services, technologies or staffing customarily provided in connection

2020   with the resident's living quarters or room; provided, however, that nothing in this section shall

2021   obviate a resident's notice and hearing rights when movement to different living quarters

2022   involves a resident moving from a Medicare-certified unit to a non-Medicare-certified unit or

2023   involves a resident moving from a non-Medicare-certified unit to a Medicare-certified unit;

2024   provided, however, that the resident shall have the right to appeal to the facility's or institution's

2025   medical director a decision to move the resident to a different living quarter or to a different

2026   room within the facility or institution.

2027                   SECTION 65. Section 72P of said chapter 111, as so appearing, is hereby amended by

2028   striking out, in line 20, the word "division" and inserting in place thereof the following word:-

2029   institute.

2030                   SECTION 66. Section 72Q of said chapter 111, as so appearing, is hereby amended by

2031   striking out, in line 2, the word "division" and inserting in place thereof the following word:-

2032   institute.

2033 SECTION 67. Section 72Y of said chapter 111, as so appearing, is hereby amended by  
2034 striking out, in lines 43 and 47, the words “7 of chapter 118G” and inserting in place thereof, in  
2035 each instance, the following words:- 13D of chapter 118E.

2036 SECTION 68. Section 78 of said chapter 111, as so appearing, is hereby amended by  
2037 striking out, in lines 19 and 20, the words “division of health care finance and policy” and  
2038 inserting in place thereof the following words:- executive office of health and human services or  
2039 a governmental unit designated by the executive office.

2040 SECTION 69. Section 78A of said chapter 111, as so appearing, is hereby amended by  
2041 striking out, in line 14, the words “division of health care finance and policy” and inserting in  
2042 place thereof the following words:- executive office of health and human services or a  
2043 governmental unit designated by the executive office.

2044 SECTION 70. Section 79 of said chapter 111, as so appearing, is hereby amended by  
2045 striking out, in line 9, the words “division of health care finance and policy” and inserting in  
2046 place thereof the following words:- executive office of health and human services or a  
2047 governmental unit designated by the executive office.

2048 SECTION 71. Section 80 of said chapter 111, as so appearing, is hereby amended by  
2049 striking out, in lines 5 and 6, the words “division of health care finance and policy” and inserting  
2050 in place thereof the following words:- executive office of health and human services or a  
2051 governmental unit designated by the executive office.

2052 SECTION 72. Said section 80 of said chapter 111, as so appearing, is hereby further  
2053 amended by striking out, in line 8, the word “division” and inserting in place thereof the  
2054 following words:- executive office.

2055 SECTION 73. Section 82 of said chapter 111, as so appearing, is hereby amended by  
2056 striking out, in lines 22 and 23, the words “division of health care finance and policy” and  
2057 inserting in place thereof the following words:- executive office of health and human services or  
2058 a governmental unit designated by the executive office.

2059 SECTION 74. Said section 82 of said chapter 111, as so appearing, is hereby further  
2060 amended by striking out, in line 24, the word “division” and inserting in place thereof the  
2061 following words:- executive office.

2062 SECTION 75. Section 88 of said chapter 111, as so appearing, is hereby amended by  
2063 striking out, in line 16, the words “division of health care finance and policy” and inserting in  
2064 place thereof the following words:- executive office of health and human services or a  
2065 governmental unit designated by the executive office.

2066 SECTION 76. Section 116A of said chapter 111, as so appearing, is hereby amended by  
2067 striking out, in line 2, the words “division of health care finance and policy” and inserting in  
2068 place thereof the following words:- executive office of health and human services or a  
2069 governmental unit designated by the executive office.

2070 SECTION 77. Section 204 of said chapter 111, as so appearing, is hereby amended by  
2071 adding the following subsection:-

2072 (f) This section shall apply to any committee formed by an individual or group to perform  
2073 the duties or functions of medical peer review, notwithstanding the fact that the formation of the  
2074 committee is not required by law or regulation or that the individual or group is not solely  
2075 affiliated with a public hospital, licensed hospital, nursing home or health maintenance  
2076 organization.

2077 SECTION 78. Section 217 of said chapter 111, as so appearing, is hereby amended by  
2078 striking out, in lines 16 and 17, the words “the health plan report card developed pursuant to  
2079 section 24 of chapter 118G”.

2080 SECTION 79. Subsection (a) of section 217 of said chapter 111, as so appearing, is  
2081 hereby amended by striking out, in line 33, the word “and”.

2082 SECTION 80. Said subsection (a) of said section 217 of said chapter 111, as so  
2083 appearing, is hereby further amended by adding the following 3 paragraphs:-

2084 (8) have the authority to promulgate regulations establishing safeguards to protect  
2085 consumers from inappropriate denials of services or treatment in connection with utilization of  
2086 any alternative payment methodologies, as defined in section 1 of chapter 12C;

2087 (9) have the authority to promulgate regulations, in consultation with the division of  
2088 insurance, establishing safeguards against, and penalties for, inappropriate selection of low cost  
2089 patients and avoidance of high cost patients by any provider or provider organization accepting  
2090 alternative payment methodologies, as such terms are defined in section 1 of chapter 12C; and

2091 (10) regulate the appeals processes established in section 23 of chapter 176O and  
2092 establish, by regulation, minimum standards for fair, fast and objective review of consumer  
2093 grievances against provider organizations registered under section 10 of chapter 12C including,  
2094 but not limited to, complaint and appeals processes regarding health care personnel, facilities,  
2095 treatment quality, restrictions on patient choice and denials of services or treatments.

2096 SECTION 81. Said section 217 of said chapter 111, as so appearing, is hereby further  
2097 amended by striking out, in lines 48 and 49, the words “the division of health care finance and

2098 policy pursuant to section 24 of chapter 118G" and inserting in place thereof the following

2099 words:- the institute of health care finance and policy.

2100 SECTION 82. Subsection (b) of said section 217 of said chapter 111, as so appearing, is

2101 hereby amended by adding the following 2 sentences:-

2102 The commissioner shall establish an external review process for the review of grievances

2103 submitted by or on behalf of patients of provider organizations registered under section 10 of

2104 chapter 12C and shall specify the maximum amount of time for the completion of a

2105 determination and review after a grievance is submitted. The department shall establish

2106 expedited review procedures applicable to emergency situations.

2107 SECTION 83. Said chapter 111 is hereby further amended by adding the following 3

2108 sections:-

2109 Section 225. (a) For the purposes of this section, the following words shall have the

2110 following meanings:—

2111 "Anatomic pathology service", histopathology, surgical pathology, cytopathology,

2112 hematology, subcellular pathology, molecular pathology and blood-banking services performed

2113 by a pathologist.

2114 "Charge", the uniform price for specific services within a revenue center of a hospital.

2115 "Cytopathology", the examination of cells from the following:

2116 (i) fluids;

2117 (ii) aspirates;

2118 (iii) washings;

2119 (iv) brushings; or

2120 (v) smears, including the pap test examination performed by a physician or under  
2121 the supervision of a physician.

2122 “Hematology”, the microscopic evaluation of bone marrow aspirates and biopsies  
2123 performed by a physician or under the supervision of a physician, and peripheral blood smears  
2124 when the attending or treating physician or technologist requests that a blood smear be reviewed  
2125 by a pathologist.

2126 “Histopathology” or “surgical pathology”, the gross and microscopic examination of  
2127 organ tissue performed by a physician or under the supervision of a physician.

2128 “Patient”, any natural person receiving health care services.

2129 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a  
2130 patient for a charge.

2131 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX  
2132 programs, other governmental payers, insurance companies, health maintenance organizations  
2133 and nonprofit hospital service corporations. Third party payer shall not include a purchaser  
2134 responsible for payment for health care services rendered by a hospital, either to the purchaser or  
2135 to the hospital.

2136 (b) A clinical laboratory or physician providing anatomic pathology services for patients  
2137 in the commonwealth shall present or cause to be presented a claim, bill or demand for payment  
2138 for these services only to the following:

2139 (i) the patient directly;

2140 (ii) the responsible insurer or other third-party payer;

2141 (iii) the hospital, public health clinic or nonprofit health clinic ordering such

2142 services;

2143 (iv) the referral laboratory or a physician's office laboratory when the physician

2144 of such laboratory performs the anatomic pathology service; or

2145 (v) the governmental agency or its specified public or private agent, agency or

2146 organization on behalf of the recipient of the services.

2147 (c) Except as provided under this section, no licensed practitioner shall, directly or

2148 indirectly, charge, bill or otherwise solicit payment for anatomic pathology services unless the

2149 services were rendered personally by the licensed practitioner or under the licensed practitioner's

2150 direct supervision under section 353 of the Public Health Service Act, 42 U.S.C. § 263a.

2151 (d) No patient, insurer, third party payer, hospital, public health clinic or non-profit health

2152 clinic shall be required to reimburse any licensed practitioner for charges or claims submitted in

2153 violation of this section.

2154 (e) Nothing in this section shall be construed to mandate the assignment of benefits for

2155 anatomic pathology services.

2156 (f) Nothing in this section shall prohibit billing between laboratories for anatomic

2157 pathology services in instances where a sample must be sent to another specialist. Nothing in this

2158 section shall authorize a physician's office laboratory to bill for anatomic pathology services

2159 when the physician of such laboratory has not performed the anatomic pathology service.

2160 (g) The board of registration in medicine may revoke, suspend or deny renewal of the  
2161 license of a practitioner who violates this section.

2162 Section 226. (a) Prior to an admission, procedure or service and upon request by a patient  
2163 or prospective patient, a health care provider shall, within 2 working days, disclose the allowed  
2164 amount or charge of the admission, procedure or service, including the amount for any facility  
2165 fees required; provided, however, that if a health care provider is unable to quote a specific  
2166 amount in advance due to the health care provider's inability to predict the specific treatment or  
2167 diagnostic code, the health care provider shall disclose the estimated maximum allowed amount  
2168 or charge for a proposed admission, procedure or service, including the amount for any facility  
2169 fees required.

2170 (b) If a patient or prospective patient is covered by a health plan, a health care provider  
2171 who participates as a network provider shall, upon request of a patient or prospective patient,  
2172 provide notice of , based on the information available to the provider at the time of the request,  
2173 sufficient information regarding the proposed admission, procedure or service for the patient or  
2174 prospective patient to use and the applicable toll-free telephone number and website of the health  
2175 plan established to disclose co-insurance, copayment and deductibles, under clause (3) of  
2176 subsection (a) of section 6 of chapter 1760. A health care provider may assist a patient or  
2177 prospective patient in using the health plan's toll-free number and website.

2178 (c) The commissioner shall, in consultation with the board of registration in medicine,  
2179 promulgate regulations to enforce this section. The commissioner may impose a fine of up to  
2180 \$1000 for each violation of this section. A health care provider aggrieved by the issuance of a

2181 fine under this section may, within 21 days of receiving notification of the commissioner's  
2182 decision to impose such fine, request an adjudicatory hearing under chapter 30A.

2183 Section 227. (a) As used in this section the following terms shall, unless the context  
2184 clearly requires otherwise, have the following meanings:

2185 "Appropriate", consistent with applicable legal, health and professional standards, the  
2186 patient's clinical and other circumstances and the patient's reasonably known wishes and beliefs.

2187 "Attending health care practitioner", a physician or nurse practitioner who has primary  
2188 responsibility for the care and treatment of the patient; provided that if more than 1 physician or  
2189 nurse practitioner share that responsibility, each of them shall have a responsibility under this  
2190 section, unless they agree to assign that responsibility to 1 of them.

2191 "Palliative care", a health care treatment, including interdisciplinary end-of-life care, and  
2192 consultation with patients and family members, to prevent or relieve pain and suffering and to  
2193 enhance the patient's quality of life, including hospice care.

2194 "Terminal illness or condition", an illness or condition which can reasonably be expected  
2195 to cause death within 6 months, whether or not treatment is provided.

2196 (b) The commissioner shall adopt regulations requiring each licensed hospital, skilled  
2197 nursing facility, health center or assisted living facility to distribute to appropriate patients in its  
2198 care information regarding the availability of palliative care and end-of-life options.

2199 (c) If a patient is diagnosed with a terminal illness or condition, the patient's attending  
2200 health care practitioner shall offer to provide the patient with information and counseling  
2201 regarding palliative care and end-of-life options appropriate to the patient, including, but not

2202 limited to: (i) the range of options appropriate to the patient; (ii) the prognosis, risks and benefits  
2203 of the various options; and (iii) the patient's legal rights to comprehensive pain and symptom  
2204 management at the end-of-life. The information and counseling may be provided orally or in  
2205 writing. Where the patient lacks capacity to reasonably understand and make informed choices  
2206 relating to palliative care, the attending health care practitioner shall provide information and  
2207 counseling under this section to a person with authority to make health care decisions for the  
2208 patient. The attending health care practitioner may arrange for information and counseling under  
2209 this section to be provided by another professionally qualified individual.

2210 If the attending health care practitioner is not willing to provide the patient with  
2211 information and counseling under this section, the attending health care practitioner shall arrange  
2212 for another physician or nurse practitioner to do so or shall refer or transfer the patient to another  
2213 physician or nurse practitioner willing to do so.

2214 (d) The department shall consult with the Hospice and Palliative Care Federation of  
2215 Massachusetts in developing educational documents, rules and regulations related to this section.

2216 SECTION 84. Section 1 of chapter 111K of the General Laws, as appearing in the 2010  
2217 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words "established by  
2218 section 18 of chapter 118G".

2219 SECTION 85. Section 10 of said chapter 111K, as so appearing, is hereby amended by  
2220 striking out, in line 2, the word "division", the second time it appears, and inserting in place  
2221 thereof the following word:- institute.

2222 SECTION 86. Section 3 of chapter 111M of the General Laws, as so appearing, is hereby  
2223 amended by striking out, in lines 10 and 11, the word “division” and inserting in place thereof, in  
2224 each instance, the following word:- institute.

2225 SECTION 87. The first paragraph of section 2 of chapter 112 of the General Laws, as so  
2226 appearing, is hereby amended by inserting after the second sentence the following 2 sentences:-  
2227 The board shall require, as a standard of eligibility for licensure, that applicants demonstrate  
2228 proficiency in the use of computerized physician order entry, e-prescribing, electronic health  
2229 records and other forms of health information technology, as determined by the board; provided,  
2230 that proficiency, at a minimum, shall mean that applicants demonstrate the skills to comply with  
2231 the “meaningful use” requirements under 45 C.F.R. Part 170.

2232 SECTION 88. Chapter 112 of the General Laws, is hereby amended by inserting, after  
2233 section 2C, the following section:-

2234 Section 2D. No physician shall enter into a contract or agreement, which creates or  
2235 establishes a partnership, employment or any other form of professional relationship that  
2236 prohibits a physician from providing testimony in an administrative or judicial hearing, including  
2237 cases of medical malpractice.

2238 SECTION 88A. Section 5 of said chapter 112, as so appearing, is hereby amended by striking  
2239 out paragraphs 6 to 8, inclusive, and inserting in place thereof the following 4 paragraphs: -

2240 The board shall collect the following information reported to it to create individual profiles on  
2241 licensees and former licensees, in a format created by the board that shall be available for  
2242 dissemination to the public:

2243 (a) a description of any criminal convictions for felonies and serious misdemeanors as  
2244 determined by the board; provided, that for the purposes of this subsection, a person shall be  
2245 deemed to be convicted of a crime if the person pleaded guilty or if the person was found or  
2246 adjudged guilty by a court of competent jurisdiction;

2247 (b) a description of any charges for felonies and serious misdemeanors as determined by the  
2248 board to which a physician pleads nolo contendere or where sufficient facts of guilt were found  
2249 and the matter was continued without a finding by a court of competent jurisdiction;

2250 (c) a description of any final board disciplinary actions and a copy of any original board  
2251 disciplinary orders;

2252 (d) a description of any final disciplinary actions by licensing boards in other states;

2253 (e) a description of revocation or involuntary restriction of privileges by a hospital, clinic or  
2254 nursing home under chapter 111 or of any employer who employs physicians licensed by the  
2255 board for the purpose of engaging in the practice of medicine in the commonwealth, for reasons  
2256 related to competence or character that have been taken by the hospital, clinic or nursing home or  
2257 employer who employs physicians licensed by the board for to engage in the practice of  
2258 medicine in the commonwealth governing body or any other official of the hospital, clinic or  
2259 nursing home or employer who employs physicians licensed by the board to engage in the  
2260 practice of medicine in the commonwealth after procedural due process has been afforded, or  
2261 the resignation from or nonrenewal of medical staff membership or the restriction of privileges at  
2262 a hospital, clinic or nursing home or employer who employs physicians licensed by the board to  
2263 engage in the practice of medicine in the commonwealth taken in lieu of or in settlement of a  
2264 pending disciplinary case related to competence or character in that hospital, clinic or nursing

2265 home or of any employer who employs physicians licensed by the board to engage in the practice  
2266 of medicine or employer who employs physicians licensed by the board for the purpose of  
2267 engaging in the practice of medicine in the commonwealth;

2268 (f) all medical malpractice court judgments and all medical malpractice arbitration awards in  
2269 which a payment is awarded to a complaining party and all settlements of medical malpractice  
2270 claims in which a payment is made to a complaining party; provided that dispositions of paid  
2271 claims shall be reported in a minimum of 3 graduated categories indicating the level of  
2272 significance of the award or settlement; provided, further that information concerning paid  
2273 medical malpractice claims shall be put in context by comparing an individual licensee's medical  
2274 malpractice judgment awards and settlements to the experience of other physicians within the  
2275 same specialty; provided, further that information concerning all settlements shall be  
2276 accompanied by the following statement: "Settlement of a claim may occur for a variety of  
2277 reasons which do not necessarily reflect negatively on the professional competence or conduct of  
2278 the physician. A payment in settlement of a medical malpractice action or claim should not be  
2279 construed as creating a presumption that medical malpractice has occurred."; provided further  
2280 that nothing in this subsection shall be construed to limit or prevent the board from providing  
2281 further explanatory information regarding the significance of categories in which settlements are  
2282 reported; provided, further that pending malpractice claims shall not be disclosed by the board to  
2283 the public; provided, further that nothing in this section shall be construed to prevent the board  
2284 from investigating and disciplining a licensee on the basis of medical malpractice claims that are  
2285 pending;

2286 (g) names of medical schools and dates of graduation;

2287 (h) graduate medical education;

2288 (i) specialty board certification;

2289 (j) number of years in practice;

2290 (k) names of the hospitals where the licensee has privileges;

2291 (l) appointments to medical school faculties and indication as to whether a licensee has a

2292 responsibility for graduate medical education within the most recent 10 years;

2293 (m) information regarding publications in peer-reviewed medical literature within the most

2294 recent 10 years;

2295 (n) information regarding professional or community service activities and awards;

2296 (o) the location of the licensee's primary practice setting;

2297 (p) the identification of any translating services that may be available at the licensee's primary

2298 practice location; and

2299 (q) an indication of whether the licensee participates in the Medicaid program.

2300 The board shall provide individual licensees with a copy of their profiles prior to release to the

2301 public. A licensee shall be provided a reasonable time to correct factual inaccuracies that appear

2302 in such profile.

2303 A physician may elect to have the physician's profile omit certain information provided under

2304 clauses (l) to (n), inclusive, concerning academic appointments and teaching responsibilities,

2305 publication in peer-reviewed journals and professional and community service awards. In

2306 collecting information for such profiles and in disseminating the same, the board shall inform  
2307 physicians that they may choose not to provide such information required under said clauses (l)  
2308 to (n), inclusive.

2309 For physicians who are no longer licensed by the board, the board shall continue to make  
2310 available the profiles of such physicians, except for those who are known by the board to be  
2311 deceased. The board shall maintain the information contained in the profiles of physicians no  
2312 longer licensed by the board as of the date the physician was last licensed, and include on the  
2313 profile a notice that the information is current only to that date.

2314 SECTION 88B. Said chapter 112 is hereby amended by striking out section 12B and  
2315 inserting in place thereof the following section:-

2316 Section 12B. No physician duly registered under sections 2, 2A, 9, 9A or 9B, no  
2317 physician assistant duly registered under section 9I or the physician assistant's employing or  
2318 supervising physician, no nurse duly registered or licensed under sections 74, 74A or 76, no  
2319 pharmacist duly registered under section 24, no pharmacy technician duly registered under  
2320 section 24C, no dentist duly registered under sections 45 or 45A, no psychologist duly licensed  
2321 under sections 118 through 129, no social worker duly licensed under sections 130 through 137,  
2322 no marriage and family therapist or mental health counselor duly licensed under sections 165  
2323 through 171, and no radiologic technologist duly licensed under section 5L of chapter 111, or  
2324 resident in another state, the District of Columbia or a province of Canada, and duly registered or  
2325 licensed in such state, district or province, who, in good faith, as a volunteer and without fee,  
2326 renders emergency care or treatment, other than in the ordinary course of said person's practice,  
2327 shall be liable in a suit for damages as a result of said person's acts or omissions; provided,

2328 further, that said person shall not be liable to a hospital for its expenses if, under such emergency  
2329 conditions, said person orders a person hospitalized or causes admission.

2330 SECTION 88C. Section 9C of said chapter 112, as so appearing, is hereby amended by striking  
2331 out the definition of “physician assistant” and inserting in place thereof the following definition:-

2332 “Physician assistant”, a person who is duly registered and licensed by the board.

2333 SECTION 88D. The first paragraph of section 9E of said chapter 112, as so appearing, is hereby  
2334 amended by striking out the third sentence.

2335 SECTION 88E. The third paragraph of said section 9E of said chapter 112, as so  
2336 appearing, is hereby further amended by striking out the second sentence.

2337 SECTION 89. Said chapter 112 is hereby further amended by inserting after section 80H  
2338 the following section:-

2339 Section 80I. When a law or rule requires a signature, certification, stamp, verification,  
2340 affidavit or endorsement by a physician, when relating to physical, behavioral, substance use  
2341 disorder or mental health, that requirement may be fulfilled by a nurse practitioner practicing  
2342 under section 80B. Nothing in this section shall be construed to expand the scope of practice of  
2343 nurse practitioners. This section shall not be construed to preclude the development of mutually  
2344 agreed upon guidelines between the nurse practitioner and supervising physician under section  
2345 80E.

2346 SECTION 90. Chapter 118E of the General Laws, as so appearing, is hereby amended by  
2347 striking out section 8 and inserting in place thereof the following section:-

2348                   Section 8. As used in this chapter the following terms and phrases shall, unless the  
2349                   context clearly requires otherwise, have the following meanings:

2350                   “Actual costs”, all direct and indirect costs incurred by a hospital or a community health  
2351                   center in providing medically necessary care and treatment to its patients, determined in  
2352                   accordance with generally accepted accounting principles.

2353                   “Acute hospital”, the teaching hospital of the University of Massachusetts Medical  
2354                   School and any hospital licensed under section 51 of chapter 111 and which contains a majority  
2355                   of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of  
2356                   public health.

2357                   “Case mix”, the description and categorization of a hospital’s patient population  
2358                   according to criteria approved by the institute including, but not limited to, primary and  
2359                   secondary diagnoses, primary and secondary procedures, illness severity, patient age and source  
2360                   of payment.

2361                   “Charge”, the uniform price for specific services within a revenue center of a hospital.

2362                   “Child”, a person who is under 18 years of age.

2363                   “Commissioner”, the commissioner of medical assistance or the secretary of elder affairs,  
2364                   as appropriate.

2365                   “Community health centers”, health centers operating in conformance with Section 330  
2366                   of United States Public Law 95-626 and shall include all community health centers which file  
2367                   cost reports as requested by the institute.

2368        “Comprehensive cancer center”, the hospital of any institution so designated by the  
2369    national cancer institute under the authority of 42 USC sections 408(a) and 408(b) organized  
2370    solely for the treatment of cancer, and offered exemption from the Medicare diagnosis related  
2371    group payment system under 42 C.F.R. 405.475(f).

2372        “Department”, the department of elder affairs.

2373        “Disproportionate share hospital”, an acute hospital that exhibits a payer mix where a  
2374    minimum of 63 per cent of the acute hospital’s gross patient service revenue is attributable to  
2375    Title XVIII and Title XIX of the federal Social Security Act other government payers and free  
2376    care.

2377        “Division”, the division of medical assistance within the executive office of health and  
2378    human services; but for the purposes of sections 9 to 52, inclusive, a reference to the word  
2379    “division” shall mean the department of elder affairs, whenever appropriate.

2380        “Emergency medical condition”, a medical condition, whether physical, behavioral,  
2381    related to a substance use disorder or mental, manifesting itself by symptoms of sufficient  
2382    severity, including severe pain, that the absence of prompt medical attention could reasonably be  
2383    expected by a prudent layperson who possesses an average knowledge of health and medicine, to  
2384    result in placing the health of the person or another person in serious jeopardy, serious  
2385    impairment to body function, or serious dysfunction of any body organ or part, or, with respect  
2386    to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42  
2387    U.S.C. section 1395dd(e)(1)(B).

2388        “Emergency services”, medically necessary health care services provided to an individual  
2389    with an emergency medical condition.

2390       “Employee”, a person who performs services primarily in the commonwealth for  
2391       remuneration for a commonwealth employer; provided, that “employee” shall not include a  
2392       person who is self-employed.

2393       “Employer”, an employer as defined in section 1 of chapter 151A.

2394       “Enrollee”, a person who becomes a member of an insurance program of the division  
2395       either individually or as a member of a family.

2396       “Executive office”, the executive office of health and human services.

2397       “Financial requirements”, a hospital’s requirement for revenue which shall include, but  
2398       not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of  
2399       depreciation of plant and equipment and the reasonable costs associated with changes in medical  
2400       practice and technology.

2401       “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which  
2402       ends in the calendar year by which it is identified.

2403       “Free care”, the following medically necessary services provided to individuals  
2404       determined to be financially unable to pay for their care, in whole or in part, under applicable  
2405       regulations of the executive office: (1) services provided by acute hospitals; (2) services  
2406       provided by community health centers; and (3) patients in situations of medical hardship in  
2407       which major expenditures for health care have depleted or can reasonably be expected to deplete  
2408       the financial resources of the individual to the extent that medical services cannot be paid, as  
2409       determined by regulations of the executive office.

2410        “General health supplies, care or rehabilitative services and accommodations”, all  
2411    supplies, care and services of medical, behavioral, substance use disorder, mental, optometric,  
2412    dental, surgical, chiropractic, podiatric, psychiatric, therapeutic, diagnostic, rehabilitative,  
2413    supportive or geriatric nature, including inpatient and outpatient hospital care and services, and  
2414    accommodations in hospitals, sanatoria, infirmaries, convalescent and nursing homes, retirement  
2415    homes, facilities established, licensed or approved under chapter 111B and providing services of  
2416    a medical or health-related nature, and similar institutions including those providing treatment,  
2417    training, instruction and care of children and adults; provided, however, that rehabilitative  
2418    service shall include only rehabilitative services of a medical or health-related nature which are  
2419    eligible for reimbursement under Title XIX of the Social Security Act.

2420        “Governmental mandate”, a state or federal statutory requirement, administrative rule,  
2421    regulation, assessment, executive order, judicial order or other governmental requirement that  
2422    directly or indirectly imposes an obligation and associated compliance cost upon a provider to  
2423    take an action or to refrain from taking an action in order to fulfill the provider’s contractual duty  
2424    to a procuring governmental unit.

2425        “Governmental unit”, the commonwealth, any department, agency board or commission  
2426    of the commonwealth and any political subdivision of the commonwealth.

2427        “Gross patient service revenue”, the total dollar amount of a hospital’s charges for  
2428    services rendered in a fiscal year.

2429        “Health care services”, supplies, care and services of medical, behavioral, substance use  
2430    disorder, mental, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic,  
2431    diagnostic, preventative, rehabilitative, supportive or geriatric nature including, but not limited

2432 to, inpatient and outpatient acute hospital care and services; services provided by a community  
2433 health center or by a sanatorium, as included in the definition of "hospital" in Title XVIII of the  
2434 federal Social Security Act, and treatment and care compatible with such services or by a health  
2435 maintenance organization.

2436 "Health insurance company", a company as defined in section 1 of chapter 175 which  
2437 engages in the business of health insurance.

2438 "Health insurance plan", the Medicare program or an individual or group contract or  
2439 other plan providing coverage of health care services and which is issued by a health insurance  
2440 company, a hospital service corporation, a medical service corporation or a health maintenance  
2441 organization.

2442 "Health maintenance organization", a company which provides or arranges for the  
2443 provision of health care services to enrolled members in exchange primarily for a prepaid per  
2444 capita or aggregate fixed sum as further defined in section 1 of chapter 176G.

2445 "Hospital", a hospital licensed under section 51 of chapter 111, the teaching hospital of  
2446 the University of Massachusetts Medical School and any psychiatric facility licensed under  
2447 section 19 of chapter 19.

2448 "Institution", a licensed hospital, nursing home or public medical institution that meets  
2449 the requirements of the secretary.

2450 "Medicaid", the jointly funded state and federal medical assistance program established  
2451 under Title XIX under section 9 of this chapter.

2452       “Medical assistance”, payment by the department, or its agent, or any predecessor or  
2453   successor agency, of all or part of the cost of the medical care and services provided to recipients  
2454   of any program established under this chapter, but not including benefits provided under section  
2455   9A.

2456       “Medical assistance program”, the Medicaid program, the Veterans Administration health  
2457   and hospital programs and any other medical assistance program operated by a governmental  
2458   unit for persons categorically eligible for such program.

2459       “Medically necessary services”, medically necessary inpatient and outpatient services as  
2460   mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall  
2461   not include: (1) non-medical services, such as social, educational and vocational services; (2)  
2462   cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and  
2463   consultations; (5) court testimony; (6) research or the provision of experimental or unproven  
2464   procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-  
2465   surgery hormone therapy; and (7) the provision of whole blood; and provided, however, that  
2466   administrative and processing costs associated with the provision of blood and its derivatives  
2467   shall be payable.

2468       “Medical benefits”, benefits provided under section 9A.

2469       “Medicare program”, the medical insurance program established by Title XVIII of the  
2470   Social Security Act.

2471       “Non-acute hospital”, a hospital which is not an acute hospital.

2472       “Patient”, a natural person receiving health care services from a hospital.

2473       “Pediatric hospital”, an acute care hospital which limits services primarily to children and  
2474 which qualifies as exempt from the Medicare Prospective Payment system regulations.

2475       “Pediatric specialty unit”, a pediatric unit of an acute care hospital in which the ratio of  
2476 licensed pediatric beds to total licensed hospital beds as of July 1, 1994, exceeded 0.20. In  
2477 calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds,  
2478 and the total of all licensed hospital beds shall include the total of all licensed acute care hospital  
2479 beds, consistent with Medicare’s acute care hospital reimbursement methodology as put forth in  
2480 the Provider Reimbursement Manual Part 1, Section 2405.3G.

2481       “Person”, an individual who resides in the commonwealth or any individual residing  
2482 outside the commonwealth who is deemed to be a resident of the commonwealth under Title  
2483 XIX.

2484       “Provider”, an institution, agency, individual or other legal entity qualified under the laws  
2485 of the commonwealth to perform the medical care or services for which medical assistance and  
2486 medical benefits are available under this chapter.

2487       “Public medical institution”, a medical institution supported in whole or in part by public  
2488 funds, either federal, state or municipal staffed by professional, medical and nursing personnel  
2489 and providing medical care, in accordance with standards established through licensing or  
2490 approval by the department of public health.

2491       “Publicly aided patient”, a person who receives hospital care and services for which a  
2492 governmental unit is liable, in whole or in part, under a statutory program of public assistance.

2493       “Purchaser”, a natural person responsible for payment for health care services rendered  
2494 by a hospital.

2495       “Reside”, to occupy an established place of abode with no present intention of definite  
2496 and early removal, but not necessarily with the intention of remaining permanently, but in no  
2497 event shall the word “reside” be construed more restrictively or less restrictively than as defined  
2498 by the Secretary under Title XIX.

2499       “Resident”, a person living in the commonwealth, as defined by the executive office by  
2500 regulation; provided, however, that such regulation shall not define a resident as a person who  
2501 moved into the commonwealth for the sole purpose of securing health insurance under this  
2502 chapter; and provided, further that confinement of a person in a nursing home, hospital or other  
2503 medical institution shall not in and of itself, suffice to qualify such person as a resident.

2504       “Revenue center”, a functioning unit of a hospital which provides distinctive services to a  
2505 patient for a charge.

2506       “Secretary”, the Secretary of the United States Department of Health and Human  
2507 Services, except as that term is used in section 2 of this chapter.

2508       “Self-employed”, a person who, at common law, is not considered to be an employee and  
2509 whose primary source of income is derived from the pursuit of a bona fide business.

2510       “Self-insurance health plan”, a plan which provides health benefits to the employees of a  
2511 business, which is not a health insurance plan, and in which the business is liable for the actual  
2512 costs of the health care services provided by the plan and administrative costs.

2513        “Social service program”, a social, mental health, developmental disabilities, habilitative,  
2514    rehabilitative, substance abuse, residential care, adult or adolescent day care, vocational,  
2515    employment and training or elder service program or accommodations, purchased by a  
2516    governmental unit or political subdivision of the executive office of health and human services,  
2517    but excluding any program, service or accommodation that: (a) is reimbursable under a Medicaid  
2518    waiver granted under section 1115 of Title XI of the Social Security Act; or (b) is funded  
2519    exclusively by a federal grant.

2520        “Social service program provider”, a provider of social service programs in the  
2521    commonwealth.

2522        “Sole community provider”, any acute hospital which qualifies as a sole community  
2523    provider under Medicare regulations or under regulations promulgated by the executive office,  
2524    which regulations shall consider factors including, but not limited to, isolated location, weather  
2525    conditions, travel conditions, percentage of Medicare, Medicaid and free care provided and the  
2526    absence of other reasonably accessible hospitals in the area; provided, that such hospitals shall  
2527    include those which are located more than 25 miles from other such hospitals in the  
2528    commonwealth and which provide services for at least 60 per cent of their primary service area.

2529        “Specialty hospital”, an acute hospital which qualifies for an exemption from the  
2530    Medicare prospective payment system regulations or an acute hospital which limits its  
2531    admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to  
2532    children or patients under obstetrical care.

2533        “State institution”, a hospital, sanatorium, infirmary, clinic and other such facility owned,  
2534    operated or administered by the commonwealth, which furnishes general health supplies, care or  
2535    rehabilitative services and accommodations.

2536        “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX  
2537    programs, other governmental payers, insurance companies, health maintenance organizations  
2538    and nonprofit hospital service corporations; provided, however, that “third party payer” shall not  
2539    include a purchaser responsible for payment for health care services rendered by a hospital,  
2540    either to the purchaser or to the hospital.

2541        “Title XIX”, Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq. or any  
2542    successor thereto.

2543        “Title XXI”, Title XXI of the Social Security Act, 42 USC 1397 et seq. or any successor  
2544    thereto.

2545        SECTION 91. Section 9C of said chapter 118E, as so appearing, is hereby amended by  
2546    striking out, in line 145, the words “established by subsection (c) of section 18 of chapter 118G”.

2547        SECTION 91A. Said chapter 118E of the General Laws is hereby amended by inserting  
2548    after section 9E the following section:-

2549        Section 9F. (a) As used in this section the following words shall, unless the context  
2550    clearly requires otherwise, have the following meanings:-

2551        “Dual eligible” or “dually eligible person”, any person age 21 or older and under age 65  
2552    who is enrolled in both Medicare and MassHealth.

2553        “Integrated care organization” or “ICO”, a comprehensive network of medical, health  
2554 care and long-term services and supports providers that integrates all components of care, either  
2555 directly or through subcontracts and has been contracted with by the executive office and  
2556 designated an ICO to provide services to dually eligible individuals under this section.

2557        (b) Members of the MassHealth dual eligible pilot program on ICOs or any successor  
2558 program integrating care for dual eligible persons shall be provided an independent community  
2559 care coordinator by the ICO or successor organization, who shall be a participant in the  
2560 member’s care team. The community care coordinator shall assist in the development of a long-  
2561 term support and services care plan. The community care coordinator shall:

2562        (i) participate in initial and ongoing assessments of the health and functional status of the  
2563 member, including determining appropriateness for long-term care support and services, either in  
2564 the form of institutional or community-based care plans and related service packages necessary  
2565 to improve or maintain enrollee health and functional status;

2566        (ii) arrange and, with the agreement of the member and the care team, coordinate the  
2567 provision of appropriate institutional and community long-term supports and services, including  
2568 assistance with the activities of daily living and instrumental activities of daily living, housing,  
2569 home-delivered meals, transportation and under specific conditions or circumstances established  
2570 by the ICO or successor organization, authorize a range and amount of community-based  
2571 services; and

2572        (iii) monitor the appropriate provision and functional outcomes of community long term  
2573 care services, according to the service plan as considered appropriate by the member and the care  
2574 team; and track member satisfaction and the appropriate provision and functional outcomes of

2575 community long-term care services, according to the service plan as considered appropriate by  
2576 the member and the care team.

2577 (c) The ICO or successor organization shall not have a direct or indirect financial  
2578 ownership interest in an entity that serves as an independent care coordinator. Providers of  
2579 institutional or community based long-term services and supports on a compensated basis shall  
2580 not function as an independent care coordinator; provided, however, that the secretary of the  
2581 executive office of health and human services may grant a waiver of this restriction upon a  
2582 finding that public necessity and convenience require such a waiver. An individual who becomes  
2583 dually eligible after the age of 60 shall receive independent care coordination services under  
2584 section 4B of chapter 19A. For the purposes of this section, an organization compensated to  
2585 provide only evaluation, assessment, coordination and fiscal intermediary services shall not be  
2586 considered a provider of long-term services and supports.

2587 SECTION 92. Section 12 of said chapter 118E, as so appearing, is hereby amended by  
2588 striking out, in line 11, the word “division” and inserting in place thereof the following word:-  
2589 institute.

2590 SECTION 93. Section 13 of said chapter 118E, as so appearing, is hereby amended by  
2591 striking out, in lines 3 and 4, the words “division of health care finance and policy established by  
2592 chapter one hundred and eighteen G, which shall be called the “division” only” and inserting in  
2593 place thereof the following words:- executive office of health and human services, which shall be  
2594 called the “executive office” only or by a governmental unit designated by the executive office.

2595            SECTION 94. Said section 13 of said chapter 118E, as so appearing, is hereby further  
2596 amended by striking out, in lines, 9, 15, 18, 20, 22, and 23 the word “division” and inserting in  
2597 place thereof, in each instance, the following words:- executive office.

2598            SECTION 95. Said section 13 of said chapter 118E, as so appearing, is hereby further  
2599 amended by striking out, in line 25, the word “division” and inserting in place thereof the  
2600 following words:- institute of health care finance and policy.

2601            SECTION 96. Section 13B of said chapter 118E, as so appearing, is hereby further  
2602 amended by striking out, in lines 11 and 12, the words “the Massachusetts health care quality and  
2603 cost council, established under section 16K of chapter 6A and”.

2604            SECTION 97. Said chapter 118E is hereby amended by inserting after section 13B the  
2605 following 10 sections:-

2606            Section 13C. The secretary of the executive office shall establish rates of payment for  
2607 health care services; provided, that the secretary may designate another governmental unit to  
2608 perform such ratemaking functions. The secretary of the executive office shall have the  
2609 responsibility for establishing rates to be paid to providers for health care services by  
2610 governmental units, including the division of industrial accidents. The rates shall be adequate to  
2611 meet the costs incurred by efficiently and economically operated facilities providing care and  
2612 services in conformity with applicable state and federal laws and regulations and quality and  
2613 safety standards and which are within the financial capacity of the commonwealth.

2614 Notwithstanding any general or special law or rule or regulation to the contrary, the secretary of  
2615 the executive office shall have the responsibility for establishing fair and adequate charges to be  
2616 used by state institutions for general health supplies, care and rehabilitative services and

2617 accommodations, which charges shall be based on the actual costs of the state institution  
2618 reasonably related, in the circumstances of each institution, to the efficient production of the  
2619 services in the institution and shall also have sole responsibility for determining rates paid for  
2620 educational assessments conducted or performed by psychologists and trained, certified  
2621 educational personnel under the tenth paragraph of section 3 of chapter 71B.

2622           The secretary of the executive office shall have the responsibility for establishing rates of  
2623 payment for social service programs which are reasonable and adequate to meet the costs which  
2624 are incurred by efficiently and economically operated social service program providers in  
2625 providing social service programs in conformity with federal and state law, regulations and  
2626 quality and safety standards; provided, that the secretary may designate another governmental  
2627 unit to perform such ratemaking functions. When establishing rates of payment for social service  
2628 programs, the secretary of the executive office shall adjust rates to take into account factors,  
2629 including, but not limited to: (a) the reasonable cost to social service program providers of any  
2630 existing or new governmental mandate that has been enacted, promulgated or imposed by any  
2631 governmental unit or federal governmental authority; (b) a cost adjustment factor to reflect  
2632 changes in reasonable costs of goods and services of social service programs including those  
2633 attributed to inflation; and (c) geographic differences in wages, benefits, housing and real estate  
2634 costs in each metropolitan statistical area of the commonwealth, and in any city or town therein  
2635 where such costs are substantially higher than the average cost within that area as a whole. The  
2636 secretary of the executive office shall not consider any of the resources specified in section 13G  
2637 when establishing, reviewing or approving rates of payment for social service programs.

2638           Section 13D. The executive office, or a governmental unit designated to perform  
2639 ratemaking functions by the executive office, (1) shall determine, after public hearing, at least

2640 annually for institutional providers, and at least biennially for non-institutional providers, the  
2641 rates to be paid by each governmental unit to providers of health care services and social service  
2642 programs; provided, however, that for the purposes of this section, social service program  
2643 providers shall be treated as non-institutional providers; (2) shall determine, after public hearing,  
2644 at least annually, the rates to be charged by each state institution for general health supplies, care  
2645 or rehabilitative services and accommodations; (3) shall certify to each affected governmental  
2646 unit the rates so determined; (4) shall determine, after public hearing, at least annually, and  
2647 certify to the division of industrial accidents of the department of labor and industries, rates of  
2648 payment for general health supplies, care or rehabilitative services and accommodations, which  
2649 rates shall be paid for services under chapter 152; (5) shall, upon request of the division of  
2650 insurance, assist the division of insurance in the performance of its duties as set forth in section 4  
2651 of chapter 176B; and (6) may establish fair and reasonable classifications upon which any rates  
2652 may be based for rest homes, nursing homes and convalescent homes; provided, however, that  
2653 the executive office shall not cause a decrease in a rate or add a penalty to a rate because such  
2654 home has an equity position which is less than 0.

2655 Such rates for nursing homes and rest homes, as defined under section 71 of chapter 11,  
2656 shall be established as of October 1 of each year. In setting such rates, the executive office shall  
2657 use as base year costs for rate determination purposes the reported costs of the calendar year not  
2658 more than 4 years prior to the current rate year, adjusted for reasonableness and to incorporate  
2659 any audit findings applicable to said base year costs. In any appeal of rates under section 13E,  
2660 the petitioner shall not be permitted to introduce into the records of such an appeal evidence of  
2661 costs for any year other than the base year used to establish the rate. Notwithstanding any other  
2662 general or special law or regulation to the contrary, except as provided in this chapter, each

2663 governmental unit shall pay to a provider of services and each state institution shall charge as a  
2664 provider of health care services, as the case may be, the rates for general health supplies, care  
2665 and rehabilitative services and accommodations determined and certified by the executive office.  
2666 In establishing rates of payment to providers of services, the executive office shall control rate  
2667 increases and shall impose such methods and standards as are necessary to ensure reimbursement  
2668 for those costs which must be incurred by efficiently and economically operated facilities and  
2669 providers. Such methods and standards may include, but shall not be limited to, the following:  
2670 peer group cost analyses; ceilings on capital and operating costs; productivity standards; caps or  
2671 other limitations on the utilization of temporary nursing or other personnel services; use of  
2672 national or regional indices to measure increases or decreases in reasonable costs; limits on  
2673 administrative costs associated with the use of management companies; the availability of  
2674 discounts for large volume purchasers; the revision of existing historical cost bases, where  
2675 applicable, to reflect norms or models of efficient service delivery; and other means to encourage  
2676 the cost-efficient delivery of services. Rates produced using these methods and standards shall be  
2677 in conformance with Title XIX, including the upper limit on provider payments.

2678           In determining rates to be paid by governmental units to providers of services, the  
2679 executive office shall include as an operating expense of a provider of services any contribution  
2680 made in lieu of taxes by such provider of services to a city or town and shall establish by  
2681 regulation those expenses treated as business deductions under the Internal Revenue Code, which  
2682 shall be included as allowable operating expenses in determining rates of reimbursement. Except  
2683 for ceilings or maximum rates of reimbursement, which are determined in accordance with rate  
2684 determination methods imposed on nursing homes, any ceiling or maximum imposed by the  
2685 executive office upon the rate of reimbursement to be paid to rest homes shall reflect the actual

2686 costs of rest home providers and shall not prevent any such rest home provider from receiving  
2687 full payment for costs necessarily incurred in the provision of services in compliance with  
2688 federal or state regulations and requirements.

2689       In determining rates to be paid by governmental units to acute-care hospitals, as defined  
2690 in section 25B of chapter 111, and any hospital or separate unit of a hospital that provides acute  
2691 psychiatric services, as defined in said section 25B, the executive office shall include as an  
2692 operating expense the reasonable cost of providing competent interpreter services as required by  
2693 section 25J of said chapter 111 or section 23A of chapter 123.

2694       No hospital shall receive reimbursement or payment from any governmental unit for  
2695 amounts paid to employees, as salary, or to consultant or other firms, as fees, where the primary  
2696 responsibility of the employees or consultants is, either directly or indirectly, to persuade or seek  
2697 to persuade the employees of the hospital to support or oppose unionization. Attorney's fees for  
2698 services rendered in dealing directly with a union, in advising hospital management of its  
2699 responsibilities under the National Labor Relations Act, or for services at an administrative  
2700 agency or court or for services by an attorney in preparation for the agency or in court  
2701 proceeding shall not be support or opposition to unionization.

2702       The executive office shall establish rates on a prospective basis, subject to rules and  
2703 regulations promulgated by the executive office.

2704       In establishing rates for nursing pools under section 72Y of chapter 111, the executive  
2705 office shall establish annually the limit for the rate for service provided by nursing pools to  
2706 licensed facilities. The executive office shall establish industry-wide class rates for such services  
2707 and shall establish separate class rates for services provided to nursing facilities and hospitals.

2708 The executive office shall establish separate rates for registered nurses, licensed practical nurses  
2709 and certified nursing assistants. The executive office may establish rates by geographic region.  
2710 The rates shall include an allowance for wages, payroll taxes and fringe benefits, which shall be  
2711 based upon, and shall not exceed, median wages, payroll taxes and fringe benefits paid to  
2712 permanent medical personnel of the same type at health care facilities in the same geographic  
2713 region. The rates shall also include an allowance for reasonable administrative expenses and a  
2714 reasonable profit factor, as determined by the executive office. The executive office may exempt  
2715 from the rates certain categories, as defined by the executive office, of fixed-term employees that  
2716 work exclusively at a particular health care facility for a period of at least 90 days and for whose  
2717 services there is a contract between a facility and a nursing pool registered with the department  
2718 of public health. The executive office shall establish procedures by which nursing pools shall  
2719 submit cost reports, which may be subject to audit, to the executive office to establish rates. The  
2720 executive office shall determine the nursing pool rate contained in this paragraph by considering  
2721 wage and benefit data collected from cost reports received from nursing pools and from health  
2722 care facilities and other relevant information gathered through other collection tools or  
2723 reasonable methodologies.

2724            Except as otherwise provided in this section any person aggrieved by any rate  
2725 determination made under this section shall have a right of appeal as provided under section 13E.

2726            The executive office may enter into such contracts or agreements with the federal  
2727 government, a political subdivision of the commonwealth or any public or private corporation or  
2728 organization, as it deems necessary; provided, however, that the executive office shall not enter  
2729 into any contract or agreement with a private corporation or organization to furnish information

2730 and statistical data to be used by said executive office as its sole basis for setting rates, if such  
2731 private corporation or organization is to make or receive payments based upon the rates so set.

2732        Each governmental unit shall cooperate with the executive office at all times in the  
2733 furtherance of the executive office's purposes. Each state institution shall permit the executive  
2734 office or any designated representatives of the executive office, to examine its books and  
2735 accounts and shall file with the executive office from time to time or upon request such data,  
2736 statistics, schedules or other information as the executive office may reasonably require.

2737        Each rate established by the executive office shall be a regulation and shall be subject to  
2738 review as hereinafter provided. The executive office shall promulgate rules and regulations for  
2739 the administration of its duties and the determination of rates as are herein required subject to the  
2740 procedures prescribed by chapter 30A. Every rate, classification and other regulation established  
2741 by the executive office shall be consistent where applicable with the principles of reimbursement  
2742 for provider costs in effect from time to time under Titles XVIII and XIX of the Social Security  
2743 Act governing reimbursements or grants available to the commonwealth, its departments,  
2744 agencies, boards, divisions or political subdivisions for general health supplies, care and  
2745 rehabilitative services and accommodations.

2746        In the event that any aggregate rates certified by the executive office exceed the upper  
2747 limit of payment in effect for any period under Titles XVIII or Title XIX of the Social Security  
2748 Act or any other requirement of said Titles, where applicable, the executive office shall re-  
2749 determine and recertify any such aggregate rates in order to bring them into compliance with  
2750 such federal requirement for the entire period during which such upper limit is effective.

2751        This section shall not apply to acute or non-acute hospitals; provided, however, that this  
2752 section shall apply to acute and non-acute hospitals for services under the workers'  
2753 compensation act.

2754        Section 13E. Except for rates established under section 13F, any person, corporation or  
2755 other party aggrieved by an interim rate or a final rate established by the executive office or a  
2756 governmental unit designated to perform ratemaking functions by the executive office, or by  
2757 failure of the executive office to set a rate or to take other action required by law and desiring a  
2758 review thereof shall, within 30 days after said rate is filed with the state secretary or may, at any  
2759 time, if there is a failure to determine a rate or take any action required by law, file an appeal  
2760 with the division of administrative law appeals established by section 4H of chapter 7. Any  
2761 appeal filed under this section shall be accompanied by a certified statement that said appeal is  
2762 not interposed for delay. On appeal, the rate determined for any provider of services shall be  
2763 adequate, fair and reasonable for such provider, based upon, the costs of such provider, but not  
2764 limited thereto.

2765        On an appeal from an interim rate or a final rate the division of administrative law  
2766 appeals shall conduct an adjudicatory proceeding under chapter 30A, and said division shall file  
2767 its decision with the secretary of the executive office and the state secretary within 30 days after  
2768 the conclusion of the hearing.

2769        Said decision shall contain a statement of the reasons for such decision, including a  
2770 determination of each issue of fact or law upon which such decision was based. If such decision  
2771 results in a recommendation for a rate different from that certified, the executive office shall  
2772 establish a new rate based upon such statement of reasons. If the secretary of the executive office

2773 determines that the statement of reasons is inadequate to determine a fair, reasonable and  
2774 adequate rate, it may remand the appeal to the hearing officer for further investigation. Any party  
2775 aggrieved by a decision of the division may, within 30 days of the receipt of such decision, file a  
2776 petition for review in superior court for the county of Suffolk, which shall have exclusive  
2777 jurisdiction of such review.

2778 A provider may appeal as an aggrieved party under the preceding sentence, in the event  
2779 that a remand by the executive office to a hearing officer does not result in a final decision by the  
2780 executive office within 21 days of the date of remand.

2781 The petition shall set forth the grounds upon which the decision of the division should be  
2782 set aside. The aggrieved party shall, within 7 days after the petition for review is filed, notify the  
2783 executive office and all the parties to the appeal before said division that a petition for review has  
2784 been filed by sending each a copy thereof. Within 40 days after the petition for review is filed, or  
2785 within such further time as the court may allow, the division of administrative law appeals shall  
2786 file in court the original or a certified copy of the record under review. The court may affirm,  
2787 modify or set aside the decision of the executive office in whole or in part, remand the decision  
2788 to the executive office for further proceedings or enter such other order as justice may require.  
2789 Nothing in this section shall be construed to prevent the division from granting temporary relief  
2790 if, in its discretion, such relief is justified nor, from informally adjusting or settling controversies  
2791 with the consent of all parties.

2792 Judicial review shall be governed by section 14 of chapter 30A to the extent not  
2793 inconsistent with this section.

2794           Section 13E ½. All purchasers and third party payers, excluding purchasers and payers  
2795   under the workers' compensation act, except as provided in chapter 152, may enter into  
2796   contractual arrangements with acute and non-acute hospitals for services. No such arrangement,  
2797   including but not limited to, prices or charges which may be charged for non-contracted services  
2798   or which may be negotiated in individual contracts between such purchasers or third party payers  
2799   and such acute or non-acute hospitals, shall be subject to prior approval by any public agency;  
2800   provided, however, that nothing in this chapter shall limit the authority of the executive office to  
2801   establish rates of payment for all health care services adjudged compensable under chapter 152,  
2802   and provided, further, that charges established by an acute or non-acute hospital for health care  
2803   services rendered shall be uniform for all patients receiving comparable services.

2804           Any acute or non-acute hospital that makes a charge or accepts payment based upon a  
2805   charge in excess of that filed, required or approved by the executive office or that fails to file any  
2806   data, statistics or schedules or other information required under this chapter or by any regulation  
2807   promulgated by the executive office or which falsifies the same, shall be subject to a civil  
2808   penalty of not more than \$1,000 for each day on which such violation occurs or continues, which  
2809   penalty may be assessed in an action brought on behalf of the commonwealth in any court of  
2810   competent jurisdiction. The attorney general shall bring any appropriate action, including  
2811   injunctive relief, as may be necessary for the enforcement of this chapter.

2812           Section 13F. All rates of payment to acute hospitals and non-acute hospitals under Title  
2813   XIX shall be established by contract between the provider of such hospital services and the  
2814   office of Medicaid, except as provided in subsections (a) and (b), or otherwise permitted by law.  
2815   All rates shall be subject to all applicable Title XIX statutory and regulatory requirements and

2816 shall include reimbursement for the reasonable cost of providing competent interpreter services  
2817 under section 25J of chapter 111 or section 23A of chapter 123.

2818 All such rates for non-acute hospitals shall be effective as of the date specified in section  
2819 13A, unless otherwise specified by law.

2820 (a) For disproportionate share hospitals, the executive office shall establish rates that  
2821 equal the financial requirements of providing care to recipients of medical assistance.

2822 (b) The executive office, or governmental unit designated by the executive office, shall  
2823 establish rates of payment which shall apply to emergency services and continuing emergency  
2824 care provided in acute hospitals to medical assistance program recipients, including examination  
2825 or treatment for an emergency medical condition or active labor in women or any other care  
2826 rendered to the extent required by 42 USC 1395(dd), unless such services are provided under an  
2827 agreement between the office of Medicaid and the acute hospital. Such rates of payment shall  
2828 reflect the reasonable costs of providing such care, including the costs of providing competent  
2829 interpreter services under section 25J of chapter 111 or section 23A of chapter 123 and shall take  
2830 into account the characteristics of the hospital in which such care is provided, including, but not  
2831 limited to, its status as a teaching hospital, specialty hospital, disproportionate share hospital,  
2832 pediatric hospital, pediatric specialty unit or sole community provider. An acute hospital shall,  
2833 when a medical assistance program recipient requires post emergency room care and, after  
2834 screening and stabilizing the patient's condition, notify the office of Medicaid or its designated  
2835 representative and assist said office, to the extent possible, in transferring the recipient to an  
2836 appropriate medical setting under said office's direction. Nothing in this section shall be  
2837 construed to require the hospital to breach its obligation under said 42 USC 1395(dd) or require

2838 the recipient to forego any right to refuse transfer under said 42 USC 1395(dd). If an acute  
2839 hospital is unable or prohibited by law or regulation from transferring the patient under said  
2840 office's direction, said executive office shall pay for any and all care associated with such  
2841 patient's treatment including, but not limited to, care or services provided in the emergency room  
2842 or in an inpatient or outpatient setting. Whenever said office is required to pay for such care  
2843 rendered in a non-emergency room setting, said office shall pay all reasonable costs for such  
2844 services in such hospital, as determined by the executive office under this chapter and consistent  
2845 with Title XIX laws.

2846 No acute hospital may charge to a governmental unit for services provided to publicly  
2847 aided patients at a rate higher than the rate payable by the office of Medicaid under Title XIX for  
2848 the same service, unless such service is provided by said office under a unique arrangement such  
2849 as a selective contract or a managed care contract.

2850 Nothing in this chapter shall be construed to conflict with a waiver of otherwise  
2851 applicable federal requirements which the office of Medicaid may obtain from the secretary of  
2852 health and human services to implement a primary care case management system for delivering  
2853 services, or to implement any other type of managed care service delivery system in which the  
2854 eligible recipient is directed to obtain services exclusively from 1 provider or 1 group of  
2855 providers.

2856 If the office of Medicaid contracts with any third party payer for the provision of medical  
2857 benefits for medical assistance recipients under Title XIX, said office shall assure that on a  
2858 quarterly basis such contracted third party payers notify each acute hospital of the number of  
2859 inpatient days of service provided by the hospital to such recipients covered by such contracts.

2860 (c) The executive office, or a governmental unit designated to perform ratemaking  
2861 functions by the executive office, shall establish rates of payment which shall apply to  
2862 community hospitals located in rural and isolated areas where access to other such providers is  
2863 not reasonably available. Such hospitals, specially designated by the commonwealth as sole  
2864 community providers, shall receive payment rates calculated to reflect the rural characteristics of  
2865 such community hospital and the essential nature of the services they provide, which rates shall  
2866 not be less than 97 per cent of such hospitals' reasonable financial requirements.

2867 Section 13G. The executive office, or a governmental unit designated to perform  
2868 ratemaking functions by the executive office, shall not consider the following as resources of  
2869 such hospitals in the establishment, review or approval of acute and non-acute hospital rates and  
2870 charges: restricted and unrestricted grants; gifts; contributions; bequests; fund principle; term  
2871 endowments and endowment balances; restricted gifts; unrestricted gifts and all income from any  
2872 of the foregoing, including unrestricted income from endowment funds and income and gains  
2873 from investment of unrestricted funds. The following words shall have the following meanings  
2874 as used in this paragraph:

2875 "Income and gains from investment of unrestricted funds", interest, dividends, rents or  
2876 other income on investments, including net gains or losses resulting from investment  
2877 transactions.

2878 "Term endowment", funds available upon termination of restrictions.

2879 "Unrestricted gifts", gifts, grants, contributions and bequests, upon which there are no  
2880 restrictions imposed by the donor.

2881        "Unrestricted income from endowment funds", income earned on investment of  
2882    endowment funds which have no restrictions on income.

2883        An acute or non-acute care hospital aggrieved by any action or failure to act by the  
2884    executive office under this chapter may file an appeal under section 13E.

2885        Section 13H. No acute hospital shall deny access to care and services which the hospital  
2886    would provide under this chapter to recipients of benefits under chapter 117A.

2887        Section 13I. Notwithstanding any provisions of this chapter to the contrary, all costs and  
2888    charges for patients who are residents of other countries shall, as provided herein, be exempted  
2889    from the limitations imposed by this chapter. Any hospital shall be allowed to impose a  
2890    surcharge on the normal charges that would otherwise be allowed for such residents of other  
2891    countries. Such surcharges shall not be included in the calculation of gross patient service  
2892    revenues. The normal charge and the patient discharge statistics shall otherwise be included  
2893    under this chapter.

2894        Section 13J. A health maintenance organization organized under chapter 176G may (i)  
2895    negotiate directly with any hospital with respect to such health maintenance organization's rate  
2896    of payment for hospital services and (ii) enter into an agreement with such hospital reflecting  
2897    such rate of payment without the approval of the executive office. The specification in this  
2898    section of contracting rights of health maintenance organizations shall not be construed as  
2899    affirming or denying such rights with respect to any other third party payer.

2900        Section 13K. Upon petition of a receiver appointed under section 72 N of chapter 111,  
2901    the executive office shall, under regulations to be promulgated hereunder, adjust the facility's  
2902    rate, if necessary, to insure compensation of the receiver and payment for a bond. Such

2903 adjustment shall not be in effect if the licensee is under the jurisdiction of the United States  
2904 Bankruptcy Court.

2905 SECTION 98. Section 14 of said chapter 118E, as appearing in the 2010 Official Edition,  
2906 is hereby amended by striking out, in lines 4 and 5 and 66, the words “division of health care  
2907 finance and policy” and inserting in place thereof, in each instance, the following words:-  
2908 executive office of health and human services or a governmental unit designated by the executive  
2909 office.

2910 SECTION 99. Subsection (e) of section 22 of said chapter 118E, as so appearing, is  
2911 hereby amended by striking out, in lines 46 and 47, the words “36 of chapter 118G” and  
2912 inserting in place thereof the following figure:- 69.

2913 SECTION 100. Subsection (k) of said section 22 of said chapter 118E, as so appearing, is  
2914 hereby amended by striking out, in lines 93 and 96, the word “118G” and inserting in place  
2915 thereof, in each instance, the following word:- 118E.

2916 SECTION 101. Said section 22 of said chapter 118E, as so appearing, is hereby amended  
2917 by striking out, in lines 44 and 45, 65, 71, 86 and 87 and 110, the words “division of health care  
2918 finance and policy” and inserting in place thereof, in each instance, the following words:-  
2919 executive office of health and human services.

2920 SECTION 102. Subsection (m) of said section 22 of said chapter 118E, as so appearing,  
2921 is hereby amended by striking out, in lines 112 and 113, the words “39 of chapter 118G” and  
2922 inserting in place thereof the following figure:- 69.

2923 SECTION 103. Section 23 of said chapter 118E, as so appearing, is hereby amended by  
2924 striking out, in line 74, the words “39 of chapter 118G” and inserting in place thereof the  
2925 following figure:- 69.

2926 SECTION 104. Said chapter 118E is hereby further amended by inserting after section 62  
2927 the following 13 sections:-

2928 Section 63. (a) For the purposes of this section, the following words shall have the  
2929 following meanings:—

2930 “Assessment”, the user fee imposed under this section; provided that for all nursing  
2931 homes, the user fee shall be imposed per non Medicare reimbursed patient day; provided, further  
2932 that a Medicare-reimbursed patient day shall be a Medicare Part A patient day paid for under  
2933 either an indemnity fee-for-service arrangement or a Medicare health maintenance organization  
2934 contract.

2935 “Nursing home”, a nursing home or a distinct part of a nursing unit of a hospital or other  
2936 facility licensed by the department of public health under section 71 of chapter 111.

2937 “Patient day”, a day of care provided to an individual patient by a nursing home.

2938 (b) Each nursing home shall pay an assessment per non-Medicare reimbursed patient day.  
2939 The assessment shall be sufficient in the aggregate to generate \$145 million in each fiscal year.  
2940 The assessment shall be implemented as a broad based health care-related fee as defined in 42  
2941 U.S.C. § 1396b(w)(3)(B). The assessment shall be paid to the executive office quarterly. The  
2942 executive office may promulgate regulations that authorize the assessment of interest on any  
2943 unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees at a

2944 rate not to exceed 5 per cent per month. The receipts from the assessment, any federal financial  
2945 participation received by the commonwealth as a result of expenditures funded by these  
2946 assessments and interest thereon shall be credited to the General Fund.

2947 (c) The secretary of the executive office shall prepare a form on which each nursing  
2948 home shall report quarterly its total patient days and shall calculate the assessment due. The  
2949 secretary of the executive office shall distribute the forms to each nursing home at least annually.  
2950 The failure to distribute the form or the failure to receive a copy of the form shall not stay the  
2951 obligation to pay the assessment by the date specified in this section. The executive office may  
2952 require additional reports, including but not limited to monthly census data, as it considers  
2953 necessary to monitor collections and compliance.

2954 (d) The executive office shall have the authority to inspect and copy the records of a  
2955 nursing home to audit its calculation of the assessment. In the event that the executive office  
2956 determines that a nursing home has either overpaid or underpaid the assessment, the executive  
2957 office shall notify the nursing home of the amount due or refund the overpayment. The executive  
2958 office may impose per diem penalties if a nursing home fails to produce documentation as  
2959 requested by the executive office.

2960 (e) In the event that a nursing home is aggrieved by a decision of the executive office as  
2961 to the amount due, the nursing home may file an appeal to the division of administrative law  
2962 appeals within 60 days of the date of the notice of underpayment or the date the notice was  
2963 received, whichever is later. The division of administrative law appeals shall conduct each  
2964 appeal as an adjudicatory proceeding under chapter 30A and a nursing home aggrieved by a

2965 decision of the division of administrative law appeals shall be entitled to judicial review under  
2966 section 14 of said chapter 30A.

2967 (f) The secretary of the executive office may enforce this section by notifying the  
2968 department of public health of unpaid assessments. Within 45 days after notice to a nursing home  
2969 of amounts due, the department shall revoke licensure of a nursing home that fails to remit  
2970 delinquent fees.

2971 (g) The executive office, in consultation with the office of Medicaid, shall promulgate  
2972 regulations necessary to implement this section.

2973 Section 64. As used in sections 64 to 69, inclusive, the following words shall, unless the  
2974 context clearly requires otherwise, have the following meanings:-

2975 "Acute hospital", the teaching hospital of the University of Massachusetts medical school  
2976 and any hospital licensed under section 51 of chapter 111 and which contains a majority of  
2977 medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public  
2978 health.

2979 "Allowable reimbursement", payment to acute hospitals and community health centers  
2980 for health services provided to uninsured or underinsured patients of the commonwealth under  
2981 section 69 and any further regulations promulgated by the health safety net office.

2982 "Ambulatory surgical center", a distinct entity that operates exclusively to provide  
2983 surgical services to patients not requiring hospitalization and meets the requirements of the  
2984 federal Health Care Financing Administration for participation in the Medicare program.

2985 "Ambulatory surgical center services", services described for purposes of the Medicare  
2986 program under 42 U.S.C. 1395k(a)(2)(F)(I); provided that "ambulatory surgical center services"  
2987 shall include facility services only and shall not include surgical procedures.

2988 "Bad debt", an account receivable based on services furnished to a patient which: (i) is  
2989 regarded as uncollectible, following reasonable collection efforts consistent with regulations of  
2990 the office, which regulations shall allow third party payers to negotiate with hospitals to collect  
2991 the bad debts of its enrollees; (ii) is charged as a credit loss; (iii) is not the obligation of a  
2992 governmental unit or the federal government or any agency thereof; and (iv) is not a  
2993 reimbursable health care service.

2994 "Community health center", a health center operating in conformance with the  
2995 requirements of Section 330 of United States Public Law 95-626, including all community health  
2996 centers which file cost reports as requested by the institute of health care finance and policy.

2997 "Director", the director of the health safety net office.

2998 "DRG", a patient classification scheme known as diagnosis related grouping, which  
2999 provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost  
3000 incurred by the hospital.

3001 "Emergency bad debt", bad debt resulting from emergency services provided by an acute  
3002 hospital to an uninsured or underinsured patient or other individual who has an emergency  
3003 medical condition that is regarded as uncollectible, following reasonable collection efforts  
3004 consistent with regulations of the office.

3005        "Emergency medical condition", a medical condition, whether physical, behavioral,  
3006 related to a substance use disorder or mental, manifesting itself by symptoms of sufficient  
3007 severity, including severe pain, that the absence of prompt medical attention could reasonably be  
3008 expected by a prudent layperson who possesses an average knowledge of health and medicine to  
3009 result in placing the health of the person or another person in serious jeopardy, serious  
3010 impairment to body function or serious dysfunction of any body organ or part or, with respect to  
3011 a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42  
3012 U.S.C. 1295dd(e)(1)(B).

3013        "Emergency services", medically necessary health care services provided to an individual  
3014 with an emergency medical condition.

3015        "Financial requirements", a hospital's requirement for revenue which shall include, but  
3016 not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of  
3017 depreciation of plant and equipment and the reasonable costs associated with changes in medical  
3018 practice and technology.

3019        "Fund", the Health Safety Net Trust Fund established under section 66.

3020        "Fund fiscal year", the 12-month period starting in October and ending in September.

3021        "Gross patient service revenue", the total dollar amount of a hospital's charges for  
3022 services rendered in a fiscal year.

3023        "Health services", medically necessary inpatient and outpatient services as mandated  
3024 under Title XIX of the federal Social Security Act; provided, that "health services" shall not  
3025 include: (1) nonmedical services, such as social, educational and vocational services; (2)

3026 cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and  
3027 consultations; (5) court testimony; (6) research or the provision of experimental or unproven  
3028 procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-  
3029 surgery hormone therapy; and (7) the provision of whole blood, but the administrative and  
3030 processing costs associated with the provision of blood and its derivatives shall be payable.

3031 "Managed care organization", a managed care organization, as defined in 42 CFR 438.2,  
3032 and any eligible health insurance plan, as defined in section 1 of chapter 118H, that contracts  
3033 with MassHealth or the commonwealth health insurance connector authority; provided, however,  
3034 that "managed care organization" shall not include a senior care organization, as defined in  
3035 section 9D of chapter 118E.

3036 "Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge  
3037 payors to acute hospitals for health services and ambulatory surgical centers for ambulatory  
3038 surgical center services; provided, however, that "payments subject to surcharge" shall not  
3039 include: (i) payments, settlements and judgments arising out of third party liability claims for  
3040 bodily injury which are paid under the terms of property or casualty insurance policies; (ii)  
3041 payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in  
3042 policies issued under chapter 176K or similar policies issued on a group basis; provided further,  
3043 that "payments subject to surcharge" shall include payments made by a managed care  
3044 organization on behalf of: (i) Medicaid recipients under age 65; and (ii) enrollees in the  
3045 commonwealth care health insurance program; and provided further, that "payments subject to  
3046 surcharge" may exclude amounts established under regulations promulgated by the division for  
3047 which the costs and efficiency of billing a surcharge payor or enforcing collection of the  
3048 surcharge from a surcharge payor would not be cost effective.

3049        "Pediatric hospital", an acute care hospital which limits services primarily to children and  
3050 which qualifies as exempt from the Medicare Prospective Payment system regulations.

3051        "Pediatric specialty unit", a pediatric unit of an acute care hospital in which the ratio of  
3052 licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20; provided  
3053 that in calculating that ratio, licensed pediatric beds shall include the total of all pediatric service  
3054 beds, and the total of all licensed hospital beds shall include the total of all licensed acute care  
3055 hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put  
3056 forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

3057        "Private sector charges", gross patient service revenue attributable to all patients less  
3058 gross patient service revenue attributable to Titles XVIII and XIX, other public-aided patients,  
3059 reimbursable health services and bad debt.

3060        "Reimbursable health services", health services provided to uninsured and underinsured  
3061 patients who are determined to be financially unable to pay for their care, in whole or part, under  
3062 applicable regulations of the office; provided that the health services are services provided by  
3063 acute hospitals or services provided by community health centers; and provided further, that such  
3064 services shall not be eligible for reimbursement by any other public or private third-party payer.

3065        "Resident", a person living in the commonwealth, as defined by the office by regulation;  
3066 provided, however, that such regulation shall not define as a resident a person who moved into  
3067 the commonwealth for the sole purpose of securing health insurance under this chapter.

3068        Confinement of a person in a nursing home, hospital or other medical institution shall not in and  
3069 of itself, suffice to qualify such person as a resident.

3070        "Surcharge payor", an individual or entity that pays for or arranges for the purchase of  
3071    health care services provided by acute hospitals and ambulatory surgical center services provided  
3072    by ambulatory surgical centers, as defined in this section; provided, however, that the term  
3073    "surcharge payor" shall include a managed care organization; and provided further, that  
3074    "surcharge payor" shall not include Title XVIII and Title XIX programs and their beneficiaries or  
3075    recipients, other governmental programs of public assistance and their beneficiaries or recipients  
3076    and the workers' compensation program established under chapter 152.

3077        "Underinsured patient", a patient whose health insurance plan or self-insurance health  
3078    plan does not pay, in whole or in part, for health services that are eligible for reimbursement  
3079    from the health safety net trust fund, provided that such patient meets income eligibility  
3080    standards set by the office.

3081        "Uninsured patient", a patient who is a resident of the commonwealth, who is not covered  
3082    by a health insurance plan or a self-insurance health plan and who is not eligible for a medical  
3083    assistance program.

3084        Section 65. (a) There shall be established within the office of Medicaid a health safety net  
3085    office which shall be under the supervision and control of a director. The director shall be  
3086    appointed by the secretary of the executive office and shall be a person of skill and experience in  
3087    the field of health care finance and administration. The director shall be the executive and  
3088    administrative head of the office and shall be responsible for administering and enforcing the law  
3089    relative to the office and to each administrative unit of the office. The director shall receive such  
3090    salary as may be determined by law, and shall devote full time to the duties of the office. In the  
3091    case of an absence or vacancy in the office of the director, or in the case of disability as

3092 determined by the secretary of the executive office, the secretary of the executive office may  
3093 designate an acting director to serve as director until the vacancy is filled or the absence or  
3094 disability ceases. The acting director shall have all the powers and duties of the director and shall  
3095 have similar qualifications as the director.

3096 (b) The office shall have the following powers and duties: (1) to administer the Health  
3097 Safety Net Trust Fund, established under section 66, and to require payments to the fund  
3098 consistent with acute hospitals' and surcharge payors' liability to the fund, as determined under  
3099 sections 67 and 68, and any further regulations promulgated by the office; (2) to set in  
3100 consultation with the office of Medicaid, reimbursement rates for payments from the fund to  
3101 acute hospitals and community health centers for reimbursable health services provided to  
3102 uninsured and underinsured patients and to disburse monies from the fund consistent with such  
3103 rates; provided that the office shall implement a fee-for-service reimbursement system for acute  
3104 hospitals; (3) to promulgate regulations further defining: (a) eligibility criteria for reimbursable  
3105 health services; (b) the scope of health services that are eligible for reimbursement by the Health  
3106 Safety Net Trust Fund; (c) standards for medical hardship; and (d) standards for reasonable  
3107 efforts to collect payments for the costs of emergency care; provided that the office shall verify  
3108 eligibility using the eligibility system of the office of Medicaid and other appropriate sources to  
3109 determine the eligibility of uninsured and underinsured patients for reimbursable health services  
3110 and shall establish other procedures to ensure that payments from the fund are made for health  
3111 services for which there is no other public or private third party payer, including disallowance of  
3112 payments to acute hospitals and community health centers for health services provided to  
3113 individuals if reimbursement is available from other public or private sources; (4) to develop  
3114 programs and guidelines to encourage maximum enrollment of uninsured individuals who

3115 receive health services reimbursed by the fund into health care plans and programs of health  
3116 insurance offered by public and private sources and to promote the delivery of care in the most  
3117 appropriate setting, provided that the programs and guidelines are developed in consultation with  
3118 the commonwealth health insurance connector, established under chapter 176Q; and provided  
3119 further that these programs shall not deny payments from the fund because services should have  
3120 been provided in a more appropriate setting if the hospital was required to provide the services  
3121 under 42 U.S.C. 1395 (dd); (5) to conduct a utilization review program designed to monitor the  
3122 appropriateness of services for which payments were made by the fund and to promote the  
3123 delivery of care in the most appropriate setting; and to administer demonstration programs that  
3124 reduce health safety net trust fund liability to acute hospitals, including a demonstration program  
3125 to enable disease management for patients with chronic diseases, substance abuse and psychiatric  
3126 disorders through enrollment of patients in community health centers and community mental  
3127 health centers and through coordination between these centers and acute hospitals, provided, that  
3128 the office shall report the results of these reviews annually to the joint committee on health care  
3129 financing and the house and senate committees on ways and means; (6) to enter into agreements  
3130 or transactions with any federal, state or municipal agency or other public institution or with a  
3131 private individual, partnership, firm, corporation, association or other entity and to make  
3132 contracts and execute all instruments necessary or convenient for the carrying on of its business;  
3133 (7) to secure payment, without imposing undue hardship upon any individual, for unpaid bills  
3134 owed to acute hospitals by individuals for health services that are ineligible for reimbursement  
3135 from the Health Safety Net Trust Fund which have been accounted for as bad debt by the  
3136 hospital and which are voluntarily referred by a hospital to the department for collection;  
3137 provided, however that such unpaid charges shall be considered debts owed to the

3138 commonwealth and all payments received shall be credited to the fund; and provided, further,  
3139 that all actions to secure such payments shall be conducted in compliance with a protocol  
3140 previously submitted by the office to the joint committee on health care financing; (8) to require  
3141 hospitals and community health centers to submit to the office data that it reasonably considers  
3142 necessary; (9) to make, amend and repeal rules and regulations to effectuate the efficient use of  
3143 monies from the Health Safety Net Trust Fund; provided, however, that the regulations shall be  
3144 promulgated only after notice and hearing and only upon consultation with the board of the  
3145 commonwealth health insurance connector, representatives of the Massachusetts Hospital  
3146 Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts  
3147 Safety Net Hospitals, the Conference of Boston Teaching Hospitals and the Massachusetts  
3148 League of Community Health Centers; and (10) to provide an annual report at the close of each  
3149 fund fiscal year to the joint committee on health care financing and the house and senate  
3150 committees on ways and means, evaluating the processes used to determine eligibility for  
3151 reimbursable health services, including the Virtual Gateway. The report shall include, but not be  
3152 limited to, the following: (i) an analysis of the effectiveness of these processes in enforcing  
3153 eligibility requirements for publicly-funded health programs and in enrolling uninsured residents  
3154 into programs of health insurance offered by public and private sources; (ii) an assessment of the  
3155 impact of these processes on the level of reimbursable health services by providers; and (iii)  
3156 recommendations for ongoing improvements that will enhance the performance of eligibility  
3157 determination systems and reduce hospital administrative costs.

3158           Section 66. (a) There shall be established and set up on the books of the commonwealth  
3159 a fund to be known as the Health Safety Net Trust Fund, in this section and in sections 67 to 69,  
3160 inclusive, called the fund, which shall be administered by the office. Expenditures from the fund

3161 shall not be subject to appropriation unless otherwise required by law. The purposes of the fund  
3162 shall be: (i) to maintain a health care safety net by reimbursing hospitals and community health  
3163 centers for a portion of the cost of reimbursable health services provided to low-income,  
3164 uninsured or underinsured residents; and (ii) to support a portion of the costs of the Medicaid  
3165 program this chapter and the commonwealth care health insurance program under chapter 118H.  
3166 The office shall administer the fund using such methods, policies, procedures, standards and  
3167 criteria that it deems necessary for the proper and efficient operation of the fund and programs  
3168 funded by it in a manner designed to distribute the fund resources as equitably as possible. The  
3169 director of the health safety net office shall determine annually the estimated expenses of the  
3170 office to administer the fund.

3171 (b) The fund shall consist of all amounts paid by acute hospitals and surcharge payors  
3172 under sections 67 and 68; all appropriations for the purpose of payments to acute hospitals or  
3173 community health centers for health services provided to uninsured and underinsured residents;  
3174 any transfers from the Commonwealth Care Trust Fund, established under section 2000 of  
3175 chapter 29; and all property and securities acquired by and through the use of monies belonging  
3176 to the fund and all interest thereon. Amounts placed in the fund shall, except for amounts  
3177 transferred to the Commonwealth Care Trust Fund, be expended by the office for payments to  
3178 hospitals and community health centers for reimbursable health services provided to uninsured  
3179 and underinsured residents of the commonwealth, consistent with the requirements of this  
3180 section and section 69 and the regulations promulgated by the office; provided, however, that  
3181 expenses of the health safety net office under subsection (a) shall be expended annually from the  
3182 fund; and provided further, that not more than \$6,000,000 shall be expended annually from the  
3183 fund for demonstration projects that use case management and other methods to reduce the

3184 liability of the fund to acute hospitals; and provided further, that any amounts collected from  
3185 surcharge payors in any year in excess of \$160,000,000, adjusted to reflect applicable surcharge  
3186 credits, shall be transferred to the General Fund to support a portion of the costs of the Medicaid  
3187 and commonwealth care health insurance programs. Any annual balance remaining in the fund  
3188 after these payments have been made shall be transferred to the Commonwealth Care Trust  
3189 Fund. All interest earned on the amounts in the fund shall be deposited or retained in the fund.  
3190 The director shall from time to time requisition from the fund amounts that the director considers  
3191 necessary to meet the current obligations of the office for the purposes of the fund and estimated  
3192 obligations for a reasonable future period.

3193                   Section 67. (a) An acute hospital's liability to the fund shall equal the product of (1) the  
3194 ratio of its private sector charges to all acute hospitals' private sector charges; and (2)  
3195 \$160,000,000. Annually, before October 1, the office shall establish each acute hospital's  
3196 liability to the fund using the best data available, as determined by the health safety net office  
3197 and shall update each acute hospital's liability to the fund as updated information becomes  
3198 available. The office shall specify by regulation an appropriate mechanism for interim  
3199 determination and payment of an acute hospital's liability to the fund. An acute hospital's  
3200 liability to the fund shall in the case of a transfer of ownership be assumed by the successor in  
3201 interest to the acute hospital.

3202                   (b) The office shall establish by regulation an appropriate mechanism for enforcing an  
3203 acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled  
3204 payment to the fund. These enforcement mechanisms may include (1) an offset by the office of  
3205 Medicaid of payments on the Title XIX claims of any such acute hospital or any health care  
3206 provider under common ownership with the acute care hospital or any successor in interest to the

3207 acute hospital, and (2) the withholding by the office of Medicaid of the amount of payment owed  
3208 to the fund, including any interest and late fees and the transfer of the withheld funds into the  
3209 fund. If the office of Medicaid offsets claims payments as ordered by the office, it shall not be  
3210 considered to be in breach of contract or any other obligation for the payment of non-contracted  
3211 services and providers whose payment is offset under an order of the division shall serve all Title  
3212 XIX recipients under the contract then in effect with the office of Medicaid, or, in the case of a  
3213 non-contracting or disproportionate share hospital, under its obligation for providing services to  
3214 Title XIX recipients under this chapter. In no event shall the office direct the office of Medicaid  
3215 to offset claims unless an acute hospital has maintained an outstanding obligation to the fund for  
3216 a period longer than 45 days and has received proper notice that the office of Medicaid intends to  
3217 initiate enforcement actions under regulations promulgated by the office.

3218           Section 68. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge  
3219 on all payments subject to surcharge as defined in section 64. The surcharge shall be distinct  
3220 from any other amount paid by a surcharge payor for the services of an acute hospital or  
3221 ambulatory surgical center. The surcharge amount shall equal the product of (i) the surcharge  
3222 percentage and (ii) amounts paid for these services by a surcharge payor. The office shall  
3223 calculate the surcharge percentage by dividing \$160,000,000 by the projected annual aggregate  
3224 payments subject to the surcharge, excluding projected annual aggregate payments based on  
3225 payments made by managed care organizations. The office shall determine the surcharge  
3226 percentage before the start of each fund fiscal year and may re-determine the surcharge  
3227 percentage before April 1 of each fund fiscal year if the office projects that the initial surcharge  
3228 percentage established the previous October will produce less than \$150,000,000 or more than  
3229 \$170,000,000 in surcharge payments, excluding payments made by managed care organizations.

3230 Before each succeeding October 1, the office shall re-determine the surcharge percentage  
3231 incorporating any adjustments from earlier years. In each determination or redetermination of the  
3232 surcharge percentage, the office shall use the best data available as determined by the office of  
3233 Medicaid and may consider the effect on projected surcharge payments of any modified or  
3234 waived enforcement under subsection (e). The office shall incorporate all adjustments, including,  
3235 but not limited to, updates or corrections or final settlement amounts, by prospective adjustment  
3236 rather than by retrospective payments or assessments.

3237 (b) Each acute hospital and ambulatory surgical center shall bill a surcharge payor an  
3238 amount equal to the surcharge described in subsection (a) as a separate and identifiable amount  
3239 distinct from any amount paid by a surcharge payor for acute hospital or ambulatory surgical  
3240 center services. Each surcharge payor shall pay the surcharge amount to the office for deposit in  
3241 the Health Safety Net Trust Fund on behalf of said acute hospital or ambulatory surgical center.  
3242 Upon the written request of a surcharge payor, the office may implement another billing or  
3243 collection method for the surcharge payor; provided, however, that the office has received all  
3244 information that it requests which is necessary to implement such billing or collection method;  
3245 and provided further, that the office shall specify by regulation the criteria for reviewing and  
3246 approving such requests and the elements of such alternative method or methods.

3247 (c) The office shall specify by regulation appropriate mechanisms that provide for  
3248 determination and payment of a surcharge payor's liability, including requirements for data to be  
3249 submitted by surcharge payors, acute hospitals and ambulatory surgical centers.

3250 (d) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be  
3251 assumed by the successor in interest to the surcharge payor.

3252 (e) The office shall establish by regulation an appropriate mechanism for enforcing a  
3253 surcharge payor's liability to the fund if a surcharge payor does not make a scheduled payment to  
3254 the fund; provided, however, that the office may, for the purpose of administrative simplicity,  
3255 establish threshold liability amounts below which enforcement may be modified or waived. Such  
3256 enforcement mechanism may include assessment of interest on the unpaid liability at a rate not to  
3257 exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5  
3258 per cent per month. Such enforcement mechanism may also include notification to the office of  
3259 Medicaid requiring an offset of payments on the claims of the surcharge payor, any entity under  
3260 common ownership or any successor in interest to the surcharge payor, from the office of  
3261 Medicaid in the amount of payment owed to the fund including any interest and penalties, and to  
3262 transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as  
3263 ordered by the office, the office of Medicaid shall be considered not to be in breach of contract  
3264 or any other obligation for payment of non-contracted services, and a surcharge payor whose  
3265 payment is offset under an order of the office shall serve all Title XIX recipients under the  
3266 contract then in effect with the executive office of health and human services. In no event shall  
3267 the office direct the office of Medicaid to offset claims unless the surcharge payor has  
3268 maintained an outstanding liability to the fund for a period longer than 45 days and has received  
3269 proper notice that the office intends to initiate enforcement actions under regulations  
3270 promulgated by the office.

3271 (f) If a surcharge payor fails to file any data, statistics or schedules or other information  
3272 required under this chapter or by any regulation promulgated by the office, the office shall  
3273 provide written notice to the payor. If a surcharge payor fails to provide required information  
3274 within 14 days after the receipt of written notice, or falsifies the same, the surcharge payor shall

3275 be subject to a civil penalty of not more than \$5,000 for each day on which the violation occurs  
3276 or continues, which penalty may be assessed in an action brought on behalf of the  
3277 commonwealth in any court of competent jurisdiction. The attorney general shall bring any  
3278 appropriate action, including injunctive relief, necessary for the enforcement of this chapter.

3279                   Section 69. (a) Reimbursements from the fund to hospitals and community health centers  
3280 for health services provided to uninsured and underinsured individuals shall be subject to further  
3281 rules and regulations promulgated by the office and shall be made in the following manner:-

3282                   (1) Reimbursements made to acute hospitals shall be based on actual claims for  
3283 health services provided to uninsured and underinsured patients that are submitted to the office,  
3284 and shall be made only after determination that the claim is eligible for reimbursement under this  
3285 chapter and any additional regulations promulgated by the office. Reimbursements for health  
3286 services provided to residents of other states and foreign countries shall be prohibited and the  
3287 office shall make payments to acute hospitals using fee-for-service rates calculated as provided  
3288 in paragraphs (5) and (6).

3289                   (2) The office shall, in consultation with the office of Medicaid, develop and  
3290 implement procedures to verify the eligibility of individuals for whom health services are billed  
3291 to the fund and to ensure that other coverage options are used fully before services are billed to  
3292 the fund, including procedures adopted under section 66. The office may recover from a third  
3293 party that is financially responsible for the costs attributable to services provided to an individual  
3294 that were paid by the fund. A payment from the fund for such services shall be recoverable from  
3295 the third party and the payment shall, after notice to the third party, operate as a lien under  
3296 section 22 . The office shall review all claims billed to the fund to determine whether the patient

3297 is eligible for medical assistance under this chapter and whether any third party is financially  
3298 responsible for the costs of care provided to the patient. In making these determinations, the  
3299 office shall verify the insurance status of each individual for whom a claim is made using all  
3300 sources of data available to the office. The office shall refuse to allow payments or shall disallow  
3301 payments to acute hospitals and community health centers for free care provided to individuals if  
3302 reimbursement is available from other public or private sources; provided, that payments shall  
3303 not be denied from the fund because services should have been provided in a more appropriate  
3304 setting if the hospital was required to provide these services under 42 U.S.C. 1395(dd).

3305 (3) The office shall require acute hospitals and community health centers to  
3306 screen each applicant for reimbursed care for other sources of coverage and for potential  
3307 eligibility for government programs and to document the results of that screening. If an acute  
3308 hospital or community health center determines that an applicant is potentially eligible for  
3309 Medicaid or for the commonwealth care health insurance program, established under chapter  
3310 118H, or another assistance program, the acute hospital or community health center shall assist  
3311 the applicant in applying for benefits under that program. The office shall audit the accounts of  
3312 acute hospitals and community health centers to determine compliance with this section and shall  
3313 deny payments from the fund for any acute hospital or community health center that fails to  
3314 document compliance with this section.

3315 (4) Notwithstanding any general or special law to the contrary, an applicant for  
3316 health safety net assistance shall, if eligible, be enrolled in MassHealth under section 9A or in the  
3317 insurance reimbursement program, as provided in section 9C. An applicant deemed ineligible  
3318 for either program and who is unable to make all or part of the payment for health services shall  
3319 provide the name and address of the applicant's employer, if any, and the applicant's name,

3320 address, social security number and date of birth. The director of labor, in collaboration with the  
3321 office, shall collaborate with the division of insurance and the department of revenue to  
3322 implement this section and section 17 of chapter 176Q.

3323 (5) To pay community health centers for health services provided to uninsured  
3324 individuals under this section, the office shall pay community health centers a base rate that shall  
3325 be no less than the then-current Medicare Federally Qualified Health Center rate as required  
3326 under 42 U.S.C. 13951 (a)(3), and the office shall add payments for additional services not  
3327 included in the base rate, including, but not limited to, EPSDT services, 340B pharmacy, urgent  
3328 care, and emergency room diversion services.

3329 (6) Reimbursements to acute hospitals and community health centers for bad debt  
3330 shall be made upon submission of evidence, in a form to be determined by the office, that  
3331 reasonable efforts to collect the debt have been made.

3332 (7) The office shall reimburse acute hospitals for health services provided to  
3333 individuals based on the payment systems in effect for acute hospitals used by the United States  
3334 Department of Health and Human Services Centers for Medicare & Medicaid Services to  
3335 administer the Medicare Program under Title XVIII of the Social Security Act, including all of  
3336 Medicare's adjustments for direct and indirect graduate medical education, disproportionate  
3337 share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of  
3338 the annual increase in the Medicare hospital market basket index. The office shall, in  
3339 consultation with the office of Medicaid and the Massachusetts Hospital Association, promulgate  
3340 regulations necessary to modify these payment systems to account for: (i) the differences  
3341 between the program administered by the office and the Title XVIII Medicare program,

3342 including the services and benefits covered; (ii) grouper and DRG relative weights for purposes  
3343 of calculating the payment rates to reimburse acute hospitals at rates no less than the rates they  
3344 are reimbursed by Medicare; (iii) the extent and duration of covered services; (iv) the  
3345 populations served; and (v) any other adjustments to the payment methodology under this section  
3346 as considered necessary by the office, based upon circumstances of individual hospitals.

3347           Following implementation of this section, the office shall ensure that the allowable  
3348 reimbursement rates under this section for health services provided to uninsured individuals shall  
3349 not thereafter be less than rates of payment for comparable services under the Medicare program,  
3350 taking into account the adjustments required by this section.

3351           (b) By April 1 of the year preceding the start of the fund fiscal year, the office shall, after  
3352 consultation with the office of Medicaid, and using the best data available, provide an estimate of  
3353 the projected total reimbursable health services provided by acute hospitals and community  
3354 health centers and emergency bad debt costs, the total funding available and any projected  
3355 shortfall after adjusting for reimbursement payments to community health centers. If a shortfall  
3356 in revenue exists in any fund fiscal year to cover projected costs for reimbursement of health  
3357 services, the office shall allocate that shortfall in a manner that reflects each hospital's  
3358 proportional financial requirement for reimbursements from the fund, including, but not limited  
3359 to, the establishment of a graduated reimbursement system and under any additional regulations  
3360 promulgated by the office.

3361           (c) The executive office of health and human services shall enter into interagency  
3362 agreements with the department of revenue to verify income data for patients whose health care  
3363 services are reimbursed by the Health Safety Net Trust Fund and to recover payments made by

3364 the fund for services provided to individuals who are ineligible to receive reimbursable health  
3365 services or on whose behalf the fund has paid for emergency bad debt. The office shall  
3366 promulgate regulations requiring acute hospitals to submit data that will enable the department of  
3367 revenue to pursue recoveries from individuals who are ineligible for reimbursable health services  
3368 and on whose behalf the fund has made payments to acute hospitals for such services or  
3369 emergency bad debt. Any amounts recovered, including amounts received under chapter 62D,  
3370 shall be deposited in the Health Safety Net Trust Fund, established in section 66.

3371 (d) The office shall not at any time make payments from the fund for any period in excess  
3372 of amounts that have been paid into or are available in the fund for that period, but the office  
3373 may temporarily prorate payments from the fund for cash flow purposes.

3374 Section 70. (a) Acute hospitals and ambulatory surgical centers shall assess a health  
3375 system benefit surcharge on all payments subject to surcharge in addition to the surcharge  
3376 assessed under section 68. The health system benefit surcharge shall be distinct from any other  
3377 amount paid by a surcharge payor for the services of an acute hospital or ambulatory surgical  
3378 center. The health system benefit surcharge amount shall equal the product of (i) the health  
3379 system benefit surcharge percentage and (ii) amounts paid for these services by a surcharge  
3380 payor. The office shall calculate the health system benefit surcharge percentage by dividing  
3381 \$40,000,000 by the projected annual aggregate payments subject to the health system benefit  
3382 surcharge, excluding projected annual aggregate payments based on payments made by managed  
3383 care organizations. The office shall determine the health system benefit surcharge percentage  
3384 before the start of each fund fiscal year and may re-determine the health system benefit  
3385 surcharge percentage before April 1 of each fund fiscal year if the office projects that the initial  
3386 health system benefit surcharge percentage established the previous October will produce less

3387 than \$30,000,000 or more than \$50,000,000 in health system benefit surcharge payments,  
3388 excluding payments made by managed care organizations. Before each succeeding October 1,  
3389 the office shall re-determine the health system benefit surcharge percentage incorporating any  
3390 adjustments from earlier years. In each determination or redetermination of the health system  
3391 benefit surcharge percentage, the office shall use the best data available as determined by the  
3392 office of Medicaid and may consider the effect on projected health system benefit surcharge  
3393 payments of any modified or waived enforcement under subsection (e). The office shall  
3394 incorporate all adjustments, including, but not limited to, updates or corrections or final  
3395 settlement amounts, by prospective adjustment rather than by retrospective payments or  
3396 assessments.

3397 (b) One half of all health system benefit surcharge payments shall be deposited in the  
3398 Prevention and Wellness Trust Fund, established in section 2G of chapter 111. One half of all  
3399 health system benefit surcharge payments shall be deposited in the e-Health Institute Fund,  
3400 established in section 6E of chapter 40J.

3401 (c) Each acute hospital and ambulatory surgical center shall bill a health system benefit  
3402 surcharge payor an amount equal to the health system benefit surcharge described in subsection  
3403 (a) as a separate and identifiable amount distinct from any amount paid by a surcharge payor for  
3404 acute hospital or ambulatory surgical center services. Each health system benefit surcharge payor  
3405 shall pay the health system benefit surcharge amount to the office for deposit in the Prevention  
3406 and Wellness Trust Fund and the e-Health Institute Fund on behalf of said acute hospital or  
3407 ambulatory surgical center. Upon the written request of a health system benefit surcharge payor,  
3408 the office may implement another billing or collection method for the health system benefit  
3409 surcharge payor; provided, however, that the office has received all information that it requests

3410 which is necessary to implement such billing or collection method; and provided further, that the  
3411 office shall specify by regulation the criteria for reviewing and approving such requests and the  
3412 elements of such alternative method or methods.

3413 (d) The office shall specify by regulation appropriate mechanisms that provide for  
3414 determination and payment of a health system benefit surcharge payor's liability, including  
3415 requirements for data to be submitted by health system benefit surcharge payors, acute hospitals  
3416 and ambulatory surgical centers.

3417 (e) A health system benefit surcharge payor's liability to the fund shall in the case of a  
3418 transfer of ownership be assumed by the successor in interest to the health system benefit  
3419 surcharge payor.

3420 (f) The office shall establish by regulation an appropriate mechanism for enforcing a  
3421 health system benefit surcharge payor's liability to the fund if a health system benefit surcharge  
3422 payor does not make a scheduled payment to the funds; provided, however, that the office may,  
3423 for the purpose of administrative simplicity, establish threshold liability amounts below which  
3424 enforcement may be modified or waived. Such enforcement mechanism may include assessment  
3425 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent  
3426 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement  
3427 mechanism may also include notification to the office of Medicaid requiring an offset of  
3428 payments on the claims of the health system benefit surcharge payor, any entity under common  
3429 ownership or any successor in interest to the health system benefit surcharge payor, from the  
3430 office of Medicaid in the amount of payment owed to the fund including any interest and  
3431 penalties and to transfer the withheld funds into said fund. If the office of Medicaid offsets

3432 claims payments as ordered by the office, the office of Medicaid shall be considered not to be in  
3433 breach of contract or any other obligation for payment of non-contracted services and a health  
3434 system benefit surcharge payor whose payment is offset under an order of the office shall serve  
3435 all Title XIX recipients under the contract then in effect with the executive office of health and  
3436 human services. In no event shall the office direct the office of Medicaid to offset claims unless  
3437 the health system benefit surcharge payor has maintained an outstanding liability to the fund for  
3438 longer than 45 days and has received proper notice that the office intends to initiate enforcement  
3439 actions under regulations promulgated by the office.

3440 (g) If a health system benefit surcharge payor fails to file any data, statistics or schedules  
3441 or other information required under this chapter or by any regulation promulgated by the office,  
3442 the office shall provide written notice to the payor. If a health system benefit surcharge payor  
3443 fails to provide required information within 14 days after the receipt of written notice, or falsifies  
3444 the same, the payor shall be subject to a civil penalty of not more than \$5,000 for each day on  
3445 which the violation occurs or continues, which penalty may be assessed in an action brought on  
3446 behalf of the commonwealth in any court of competent jurisdiction. The attorney general shall  
3447 bring any appropriate action, including injunctive relief, necessary for the enforcement of this  
3448 chapter.

3449 Section 71. As used in sections 71 to 76 inclusive, the following words shall, unless the  
3450 context requires otherwise, have the following meanings:—

3451 “Consumer,” a person to whom a personal care attendant provides personal care services.  
3452 “PCA quality home care workforce council”, “workforce council” or “the council”, the  
3453 Personal Care Attendant quality home care workforce council established under section 72.

3454        “Personal care attendant,” a person, including a personal aide, who has been selected by a  
3455 consumer or the consumer’s surrogate to provide personal care services to persons with  
3456 disabilities or seniors under the MassHealth personal care attendant program or any successor  
3457 program.

3458        “Surrogate” means the consumer’s legal guardian or person identified in a written  
3459 agreement with the consumer as responsible for hiring, directing and firing on behalf of the  
3460 consumer.

3461        Section 72. (a) The PCA quality home care workforce council is established in the  
3462 executive office of health and human services but shall not be subject to the control thereof to  
3463 ensure the quality of long-term, in-home, personal care by recruiting, training and stabilizing the  
3464 work force of personal care attendants.

3465        (b) The PCA quality home care workforce council shall consist of 9 members appointed  
3466 under this section. At all times, a majority of the members of the council shall be consumers as  
3467 defined in this chapter. In making appointments to the council, the governor shall appoint the  
3468 secretary of the executive office of health and human services or a designee, who shall serve as  
3469 chair, the secretary of labor and workforce development or a designee and 1 member from a slate  
3470 of 3 consumers recommended by the governor's special advisory commission on disability  
3471 policy. The auditor shall appoint 1 member from a slate of 3 consumers recommended by the  
3472 developmental disabilities council, 1 member from a slate of 3 consumers recommended by the  
3473 Massachusetts office on disability, and 1 member from a slate of 3 consumers recommended by  
3474 the statewide independent living council. The attorney general shall appoint 1 member from a  
3475 slate of 3 consumers or consumer surrogates recommended by the Massachusetts home care

3476 association, 1 member from a slate of 3 consumers or consumer surrogates recommended by the  
3477 Massachusetts council on aging and 1 member chosen at the attorney general's discretion. The  
3478 secretary of the executive office of health and human services or a designee and the secretary of  
3479 labor and workforce development or a designee shall be permanent members during their term in  
3480 office. Appointees to the council shall serve 3-year terms. If a vacancy occurs, the executive  
3481 officer who made the original appointment shall appoint a new council member to serve the  
3482 remainder of the unexpired term or, in the event that the vacancy occurs as the result of the  
3483 completion of a term, to serve a full term, and such appointment shall become immediately  
3484 effective upon the member taking the appropriate oath. If the departing council member was  
3485 appointed under a recommendation made under this paragraph, the executive officer shall make  
3486 the new appointment from a slate of 3 recommendations put forth by the entity that originally  
3487 recommended the departing council member. Members of the council may serve for successive  
3488 terms of office. A majority of the council shall constitute a quorum for the transaction of any  
3489 business. Members of the council shall not receive compensation for their council service but  
3490 members shall be reimbursed for their actual expenses necessarily incurred in the performance of  
3491 their duties.

3492 Section 73. (a) The workforce council shall carry out the following duties:

3493 (1) Undertake recruiting efforts to identify and recruit prospective personal care  
3494 attendants;

3495 (2) Provide training opportunities, either directly or through contract, for personal  
3496 care attendants and consumers;

3497 (3) Provide assistance to consumers and consumer surrogates in finding personal  
3498 care attendants by establishing a referral directory of personal care attendants; provided that  
3499 before placing a personal care attendant on the referral directory, the workforce council shall  
3500 determine that the personal care attendant has met the requirements established by the executive  
3501 office in its applicable regulations and has not stated in writing a desire to be excluded from the  
3502 directory;

3503 (4) Provide routine, emergency and respite referrals of personal care attendants to  
3504 consumers and consumer surrogates who are authorized to receive long-term, in-home personal  
3505 care services through a personal care attendant;

3506 (5) Give preference in the recruiting, training, referral and employment of  
3507 personal care attendants to recipients of public assistance or other low-income persons who  
3508 would qualify for public assistance in the absence of such employment; and

3509 (6) Cooperate with state and local agencies on health and aging and other federal,  
3510 state and local agencies to provide the services described and set forth in this section. If, in the  
3511 course of carrying out its duties, the PCA quality home care workforce council identifies  
3512 concerns regarding the services being provided by a personal care attendant, the workforce  
3513 council shall notify the relevant office.

3514 (b) In determining how best to carry out its duties, the PCA quality home care workforce  
3515 council shall identify existing personal care attendant recruitment, training and referral resources  
3516 made available to consumers or the consumer's surrogate by other state and local public, private  
3517 and nonprofit agencies. The council may coordinate with the agencies to provide a local presence  
3518 for the council and to provide consumers or the consumer's surrogate greater access to personal

3519 care attendant recruitment, training and referral resources in a cost-effective manner. Using  
3520 requests for proposals or similar processes, the council may contract with the agencies to provide  
3521 recruitment, training and referral. The council shall provide an opportunity for consumer  
3522 participation in coordination efforts.

3523 (c) The commonwealth shall provide to the council a list of all personal care attendants  
3524 who have been paid through the MassHealth personal care attendant program and shall update  
3525 the list not less frequently than every 6 months to ensure that the council has a complete and  
3526 accurate list at all times.

3527 Section 74. (a) Consumers or the consumer's surrogate shall retain the right to select,  
3528 hire, schedule, train, direct, supervise and terminate any personal care attendant providing  
3529 services to them. Consumers or the consumer's surrogate may elect to receive long-term, in-  
3530 home personal care services from personal care attendants who are not referred to them by the  
3531 council.

3532 (b) Personal care attendants shall be considered public employees, as defined by and  
3533 solely for the purposes of, chapter 150E and section 17J of chapter 180. Said chapter 150E shall  
3534 apply to personal care attendants except to the extent that chapter 150E is inconsistent with this  
3535 section, in which case this section shall control. In addition, personal care attendants shall be  
3536 treated as state employees solely for the purposes of sections 17A and 17G of chapter 180.

3537 Personal care attendants shall not be considered public employees or state employees for any  
3538 purpose other than those set forth in this paragraph. The PCA quality home care workforce  
3539 council shall be the employer, as defined by and solely for the purposes of said chapter 150E and  
3540 said sections 17A, 17G and 17J of said chapter 180 and deductions under said sections 17A, 17G

3541 and 17J may be made by any entity authorized by the commonwealth to compensate personal  
3542 care attendants through the MassHealth personal care attendant program. Personal care  
3543 attendants shall not be eligible for benefits through the group insurance commission, the state  
3544 board of retirement or the state employee workers' compensation program.

3545 (c) Personal care attendants who are employees of the council under this section shall not  
3546 be considered, for that reason, public employees or employees of the council for any other  
3547 purpose. Nothing in this chapter shall alter the obligations of the commonwealth or the consumer  
3548 to provide their share of social security, federal and state unemployment taxes, Medicare and  
3549 worker's compensation insurance under the Federal Insurance Contributions Act, federal and  
3550 state unemployment law or the Massachusetts Workers' Compensation Act.

3551 (d) Consistent with section 9A of chapter 150E, no personal care attendant shall engage  
3552 in a strike and no personal care attendant shall induce, encourage or condone any strike, work  
3553 stoppage, slowdown or withholding of services by any personal care attendant.

3554 (e) The only bargaining unit appropriate for the purpose of collective bargaining shall be  
3555 a statewide unit of all personal care attendants. The showing of interest required to request an  
3556 election is 10 per cent of the bargaining unit. An intervener seeking to appear on the ballot must  
3557 make the same showing of interest.

3558 (f) The council or its contractors, may not be held vicariously liable for the action or  
3559 inaction of any personal care attendant, whether or not that personal care attendant was included  
3560 on the council's referral directory or referred to a consumer or the consumer's surrogate.

3561 (g) The members of the council shall be immune from any liability resulting from  
3562 implementation of sections 71 to 76, inclusive.

3563 Section 75. (a) The PCA quality home care workforce council may make and execute  
3564 contracts and all other instruments necessary or convenient for the performance of its duties or  
3565 exercise of its powers, including contracts with public and private agencies, organizations,  
3566 corporations and individuals to pay them for services rendered or furnished.

3567 (b) The council may offer and provide recruitment, training and referral services to  
3568 personal care attendants and consumers of long-term in-home personal care services other than  
3569 statutorily defined personal care attendants and consumers, for a fee to be determined by the  
3570 council.

3571 (c) The council may issue rules or regulations, as necessary, for the purpose and policies  
3572 of sections 71 to 76, inclusive.

3573 (d) Subject to appropriation, the chairperson of the council with the council's approval  
3574 may establish offices, employ and discharge employees, agents and contractors as necessary, and  
3575 prescribe their duties and powers and fix their compensation, incur expenses, and create such  
3576 liabilities as are reasonable and proper for the administration of sections 71 to 76, inclusive.

3577 (e) The council may solicit and accept for use any grant of money, services or property  
3578 from the federal government, the state or any political subdivision or agency thereof, including  
3579 federal matching funds under Title XIX of the Federal Social Security Act, and do all things  
3580 necessary to cooperate with the federal government, the state, or any political subdivision or  
3581 agency thereof, in making an application for any grant.

3582 (f) The council may coordinate its activities and cooperate with similar agencies in other  
3583 states.

3584 (g) The council may establish technical advisory committees to assist the council.

3585 (h) The council may keep records and engage in research and the gathering of relevant  
3586 statistics.

3587 (i) The council may acquire, hold or dispose of real or personal property, or any interest  
3588 therein, and construct, lease or otherwise provide facilities for the activities conducted under  
3589 sections 71 to 76, inclusive, but the workforce council may not exercise any power of eminent  
3590 domain.

3591 (j) The council may delegate to the appropriate persons the power to execute contracts  
3592 and other instruments on its behalf and delegate any of its powers and duties, if consistent with  
3593 sections 71 to 76, inclusive.

3594 (k) The council may perform other acts necessary or convenient to execute the powers  
3595 expressly granted to it.

3596 Section 76. (a) The council shall conduct a performance review every 2 years, submit a  
3597 report of the review to the legislature and the governor and make the report available to the  
3598 public upon submission to the governor and the legislature.

3599 (b) The performance review and report shall include an evaluation of the health, welfare  
3600 and satisfaction with services provided of the consumers receiving long-term in-home personal  
3601 care services from personal care attendants under sections 71 to 76, inclusive, including the  
3602 degree to which all required services have been delivered, the degree to which consumers  
3603 receiving services from personal care attendants have ultimately required additional or more  
3604 intensive services, such as home health care, or have been placed in other residential settings or

3605 nursing homes, the promptness of response to consumer complaints and any other issue  
3606 considered to be relevant.

3607 (c) The performance review report shall provide an explanation of the full cost of  
3608 personal care services, including the administrative costs of the council, unemployment  
3609 compensation, Social Security and Medicare payroll taxes paid and any oversight costs.

3610 (d) The performance review report shall make recommendations to the legislature and the  
3611 governor for any amendments to sections 71 to 76, inclusive to further ensure the well-being of  
3612 consumers, and the most efficient means of delivering required services.

3613 SECTION 105. Chapter 118G of the General Laws is hereby repealed.

3614 SECTION 106. Section 14 of chapter 122 of the General Laws, as appearing in the 2010  
3615 Official Edition, is hereby amended by striking out, in lines 17 and 18, the words “division of  
3616 health care finance and policy” and inserting in place thereof the following words:- executive  
3617 office of health and human services or a governmental unit designated by the executive office.

3618 SECTION 107. Section 32 of chapter 123 of the General Laws, as so appearing, is hereby  
3619 amended by striking out, in lines 4 and 5, the words “division of health care finance and policy”  
3620 and inserting in place thereof the following words:- executive office of health and human  
3621 services or a governmental unit designated by the executive office.

3622 SECTION 108. Section 33 of said chapter 123, as so appearing, is hereby amended by  
3623 striking out, in lines 20 and 25, the words “division of health care finance and policy” and  
3624 inserting in place thereof, in each instance, the following words:- executive office of health and  
3625 human services or a governmental unit designated by the executive office.

3626 SECTION 109. Section 16 of chapter 123B of the General Laws, as so appearing, is  
3627 hereby amended by striking out, in lines 4 and 5, the words “division of health care finance and  
3628 policy” and inserting in place thereof the following words:- executive office of health and human  
3629 services or a governmental unit designated by the executive office.

3630 SECTION 110. Chapter 149 of the General Laws is hereby amended by striking out  
3631 section 6D ½, as so appearing, and inserting in place thereof the following section:-

3632 Section 6D ½. No employee shall be penalized by an employer as a result of such  
3633 employee’s filing of an application to the Health Safety Net Trust Fund or otherwise providing  
3634 notice to the executive office of health and human services or to a health care provider in regard  
3635 to the need for health care services for that employee that results in the employer being required  
3636 to reimburse the fund in whole or in part.

3637 SECTION 111. Subsection (a) of section 188 of said chapter 149, as so appearing, is  
3638 hereby amended by striking out the definition of “commissioner” and inserting in place thereof  
3639 the following definition:- “Connector”, the commonwealth health insurance connector  
3640 established by chapter 176Q.

3641 SECTION 112. Said subsection (a) of said section 188 of said chapter 149, as so  
3642 appearing, is hereby further amended by striking out the definition of “division”.

3643 SECTION 113. Subsection (c) of said section 188 of said chapter 149, as amended by  
3644 section 134 of chapter 3 of the acts of 2011, is hereby further amended by striking out, in line 29,  
3645 the words “commissioner of health care finance and policy”, , and inserting in place thereof the  
3646 following word:- connector.

3647 SECTION 114. Said subsection (c) of said section 188 of said chapter 149, as so  
3648 amended, is hereby further amended by striking out, in lines 42, 57, 60, 69 and 70 the word  
3649 "division" and inserting in place thereof, in each instance, the following word:- connector.

3650 SECTION 114A. Said subsection (c) of said section 188 of said chapter 149, as so  
3651 amended, is hereby further amended by adding the following clause:-

3652 (11) In calculating the fair share assessment, employees who have qualifying health  
3653 insurance coverage from a spouse, parent, veteran's plan, Medicare, Medicaid or a plan or plans  
3654 due to a disability or retirement shall not be included in the numerator or denominator for  
3655 purposes of determining whether an employer is a contributing employer, as defined in 114.5  
3656 CMR 16.02.

3657 SECTION 115. Said section 188 of said chapter 149, as appearing in the 2010 Official  
3658 Edition, is hereby amended by striking out, in lines 37 and 38, and in line 41, the words  
3659 "uncompensated care pool, or any successor thereto" and inserting in place thereof, in each  
3660 instance, the following words:- health safety net.

3661 SECTION 116. Section 1 of chapter 150E of the General Laws, as amended by section  
3662 23 of chapter 93 of the acts of 2011, is hereby amended by striking out the words "28 of chapter  
3663 118G" and inserting in place thereof the following words:- 70 of chapter 118E.

3664 SECTION 117. Said section 1 of said chapter 150E of the General Laws, as so amended,  
3665 is hereby further amended by striking out the words "29 of chapter 118G" and inserting in place  
3666 thereof the following words:- 71 of chapter 118E.

3667 SECTION 118. Subsection (c) of section 46 of chapter 151A of the General Laws, as  
3668 appearing in the 2010 Official Edition, is hereby amended by striking out clause (7) and inserting  
3669 in place thereof the following 2 clauses:-

3670 (7) to the commonwealth health insurance connector, information under an interagency  
3671 agreement for the administration and enforcement of sections 17 and 18 of chapter 176Q and for  
3672 the administration of the fair share employer contribution requirement under section 188 of  
3673 chapter 149.

3674 (7 ½) to the executive office of health and human services, information under an  
3675 interagency agreement for the administration and enforcement of paragraph (4) of subsection (a)  
3676 of section 69 of chapter 118E.

3677 SECTION 119. Section 13 of chapter 152 of the General Laws, as so appearing, is hereby  
3678 amended by striking out, in lines 3 and 4, the words “division of health care finance and policy  
3679 under the provisions of chapter one hundred and eighteen G” and inserting in place thereof the  
3680 following words:- executive office of health and human services under chapter 118E or a  
3681 governmental unit designated by the executive office.

3682 SECTION 120. Said section 13 of said chapter 152, as so appearing, is hereby further  
3683 amended by striking out, in lines 9, 10, 16 and 21, the word “division” and inserting in place  
3684 thereof, in each instance, the following words:- executive office.

3685 SECTION 121. Said section 13 of said chapter 152, as so appearing, is hereby further  
3686 amended by striking out, in lines 22 and 23, the words “one hundred and eighteen G” and  
3687 inserting in place thereof the following word:- 118E.

3688            SECTION 122. Said section 13 of said chapter 152, as so appearing, is hereby further  
3689 amended by striking out, in line 37, the words “one hundred and eighteen G” and inserting in  
3690 place thereof the following word:- 118E.

3691            SECTION 122A. Chapter 175 of the General Laws is hereby amended by inserting after  
3692 section 47AA, the following section:-

3693            Section 47BB. For the purposes of this section, “telemedicine” as it pertains to the  
3694 delivery of health care services, shall mean the use of interactive audio, video or other electronic  
3695 media for the purpose of diagnosis, consultation or treatment. “Telemedicine” shall not include  
3696 the use of audio-only telephone, facsimile machine or e-mail.

3697            An insurer may limit coverage of telemedicine services to those health care providers in a  
3698 telemedicine network approved by the insurer.

3699            A contract that provides coverage for services under this section may contain a provision  
3700 for a deductible, copayment or coinsurance requirement for a health care service provided  
3701 through telemedicine as long as the deductible, copayment or coinsurance does not exceed the  
3702 deductible, copayment or coinsurance applicable to an in-person consultation.

3703            Coverage for health care services under this section shall be consistent with coverage for  
3704 health care services provided through in-person consultation.

3705            SECTION 123. Section 5 of chapter 176A of the General Laws, as so appearing, is  
3706 hereby amended by striking out, in lines 34 and 35, the words “division of health care finance  
3707 and policy, in this section called the division” and inserting in place thereof the following

3708 words:- executive office of health and human services, in this section called the executive office,  
3709 or a governmental unit designated by the executive office.

3710 SECTION 124. Section 17 of said chapter 176A, as so appearing, is hereby amended by  
3711 striking out, in lines 4 and 10, the word “division” and inserting in place thereof, in each  
3712 instance, the following word:- institute.

3713 SECTION 124A. Section 6 of chapter 176J of the General Laws is hereby amended by  
3714 striking subsection (c), as most recently amended by section 31A of chapter 359 of the acts of  
3715 2010, and inserting in place thereof the following subsection:-

3716 (c) Notwithstanding any general or special law to the contrary, the commissioner may  
3717 require carriers offering small group health insurance plans, including carriers licensed under  
3718 chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to  
3719 small group rating factors at least 90 days before their proposed effective date. The  
3720 commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate  
3721 or unreasonable in relation to the benefits charged. The commissioner shall disapprove any  
3722 change to small group rating factors that is discriminatory or not actuarially sound. The  
3723 determination of the commissioner shall be supported by sound actuarial assumptions and  
3724 methods, which shall be provided in writing to the carrier. Rate filing materials submitted for  
3725 review by the division shall be deemed confidential and exempt from the definition of public  
3726 records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt  
3727 regulations to carry out this section.

3728 SECTION 125. Subsection (d) of section 6 of chapter 176J of the General Laws, as  
3729 appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 61 to 64,

3730 inclusive the words “, with the exception of any carrier whose Risk Based Capital Ratio, on a  
3731 combined entity basis, falls below 300% for the most recent four consecutive quarters. For such  
3732 carriers the reported contribution to surplus may not exceed 2.5 per cent”, and inserting in place  
3733 thereof the following words:-; provided, however, that for any carrier whose Risk Based Capital  
3734 Ratio, on a combined entity basis, falls below 300 per cent for the most recent 4 consecutive  
3735 quarters, the reported contribution to surplus may not exceed 2.5 per cent; provided further, that  
3736 for any carrier whose Risk Based Capital Ratio, on a combined entity basis, is greater than 600  
3737 per cent for the most recent 4 consecutive quarters, the reported contribution to surplus shall not  
3738 exceed 0.5 per cent; and provided further, that for any carrier whose Risk Based Capital Ratio is  
3739 greater than 700 per cent for the 4 most recent 4 consecutive quarters, the reported contribution  
3740 to surplus shall not exceed 0 per cent.

3741 SECTION 126. The second sentence of the second paragraph of subsection (a) of section  
3742 11 of chapter 176J of the General Laws, as so appearing, is hereby amended by striking out, in  
3743 lines 70 and 74, the words “6 of chapter 118G” and inserting in place thereof, in each instance,  
3744 the following words:- 10 of chapter 12C.

3745 SECTION 127. Section 12 of said chapter 176J, as so appearing, is hereby amended by  
3746 striking out, in line 59, the word “division” and inserting in place thereof the following word:-  
3747 institute.

3748 SECTION 128. Said section 12 of said chapter 176J, as so appearing, is hereby further  
3749 amended by adding the following subsection:-

3750 (h) Any rates offered by a carrier to a certified group purchasing cooperative under this  
3751 section shall be based on those group base premium rates that apply to individuals and small  
3752 employer groups enrolling outside the group purchasing cooperative but may differ based on:

3753 (1) a benefit rate adjustment factor that would apply to the certified group  
3754 purchasing cooperative product if its covered benefits are different than those that apply outside  
3755 the certified group purchasing cooperative;  
3756 (2) a cooperative adjustment factor that would reflect the relative difference in  
3757 the projected experience of the members projected to be enrolled in health benefit plans through  
3758 the certified group purchasing cooperative relative to the projected experience of the members  
3759 projected to be enrolled in health benefit plans outside the certified group purchasing  
3760 cooperative; or

3761 (3) any other rate adjustment factor resulting in a discount of up to 10 per cent.  
3762 Any adjustment greater than 10 per cent shall require prior approval in writing from the  
3763 commissioner.

3764 SECTION 129. Subsection (e) of section 5 of chapter 176M of the General Laws, as so  
3765 appearing, is hereby amended by striking out, in lines 94 to 96, the words "division of health care  
3766 finance and policy established under chapter one hundred and eighteen G" and inserting in place  
3767 thereof the following words:- institute of health care finance and policy established under chapter  
3768 12C.

3769 SECTION 130. Said subsection (e) of said section 5 of said chapter 176M, as so  
3770 appearing, is hereby further amended by striking out, in line 99, the word "division" and  
3771 inserting in place thereof the following word:- institute.

3772 SECTION 131. Section 1 of chapter 176O of the General Laws, as so appearing, is  
3773 hereby amended by inserting after the definition of “Adverse determination” the following  
3774 definition:-

3775 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health  
3776 care provider for health care services provided to an insured.

3777 SECTION 131A. Said section 1 of said chapter 176O, as so appearing, is hereby further  
3778 amended by striking out the definition of “Behavioral health manager” and inserting in place  
3779 thereof the following definition:-

3780 “Behavioral health manager”, a company, organized under the law of the commonwealth or  
3781 organized under the laws of another state and qualified to do business in the commonwealth, that  
3782 has entered into a contractual arrangement with a carrier to provide or arrange for the provision  
3783 of behavioral, substance use disorder and mental health services to voluntarily enrolled member  
3784 of the carrier.

3785 SECTION 131B. Said section 1 of said chapter 176O, as so appearing, is hereby further  
3786 amended by striking out the definition of “Emergency medical condition” and inserting in place  
3787 thereof the following definition:-

3788 “Emergency medical condition”, a medical condition, whether physical, behavioral, related to  
3789 substance use disorder, or mental, manifesting itself by symptoms of sufficient severity,  
3790 including severe pain, that the absence of prompt medical attention could reasonably be expected  
3791 by a prudent layperson who possesses an average knowledge of health and medicine, to result in  
3792 placing the health of the insured or another person in serious jeopardy, serious impairment to  
3793 body function or serious dysfunction of any body organ or part or, with respect to a pregnant

3794 woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section  
3795 1395dd(e)(1)(B).

3796 SECTION 131C. Said section 1 of said chapter 176O, as so appearing, is hereby further  
3797 amended by striking out the definition of “Health care services” and inserting in place thereof  
3798 the following definition:-

3799 “Health care services”, services for the diagnosis, prevention, treatment, cure or relief of  
3800 a physical, behavioral, substance use disorder or mental health condition, illness, injury or  
3801 disease.

3802 SECTION 132. Said section 1 of said chapter 176O, as so appearing, is hereby further  
3803 amended by striking out the definition of “Incentive plan” and inserting in place thereof the  
3804 following definition:-

3805 “Incentive plan,” any compensation arrangement between a carrier and licensed health  
3806 care professional or registered provider organization or organization that employs or utilizes  
3807 services of 1 or more licensed health care professionals that may directly or indirectly have the  
3808 effect of reducing or limiting services furnished to insureds of the organization.

3809 SECTION 133. Said section 1 of said chapter 176O, as so appearing, is hereby further  
3810 amended by striking out the definition of “Licensed health care provider group”.

3811 SECTION 134. Said section 1 of said chapter 176O, as so appearing, is hereby further  
3812 amended by inserting after the definition of “Prospective review” the following 2 definitions:-

3813 “Provider organization,” any corporation, partnership, business trust, association or  
3814 organized group of persons whether incorporated or not that consists of or represents 1 or more

3815 providers in contracting with carriers for the payments the provider or providers receive for the  
3816 provision of heath care services or as further defined in regulations promulgated by the institute  
3817 of health care finance and policy under chapter 12C; provided, that “provider organization” shall  
3818 include, but not be limited to, physician organizations, physician-hospital organizations,  
3819 independent practice associations, provider networks, accountable care organizations and any  
3820 other organization that contracts with carriers for payment for health care services.

3821           “Registered provider organization” a provider organization that has been registered under  
3822 chapter 12C.

3823           SECTION 135. Section 2 of chapter 176O of the General Laws, as so appearing, is  
3824 hereby amended by striking out, in line 22, the word “division” and inserting in place thereof the  
3825 following word:- institute.

3826           SECTION 136. Section 5B of said chapter 176O, as so appearing, is hereby amended by  
3827 striking out, in lines 11 and 12, the words “the division of health care finance and policy, the  
3828 health care quality and cost council” and inserting in place thereof the following words:- the  
3829 institute of health care finance and policy.

3830 SECTION 136A. Said chapter 176O is hereby amended by inserting after section 5B the  
3831 following section:-

3832           Section 5C. If the commissioner determines that a carrier is neglecting to comply with the  
3833 coding standards and guidelines under this chapter in the form and within the time required the  
3834 commissioner shall notify the carrier of such neglect. If the carrier does not come into  
3835 compliance within a period determined by the commissioner, the carrier shall be fined \$5000 for  
3836 each day during which such neglect continues.

3837 SECTION 137. Subsection (a) of section 6 of said chapter 176O, as so appearing, is  
3838 hereby amended by striking out clauses (3) and (4) and inserting in place thereof the following 2  
3839 clauses:-

3840 (3) the limitations on the scope of health care services and any other benefits to be  
3841 provided, including: (i) all restrictions relating to preexisting condition exclusions; (ii) an  
3842 explanation of any facility fee, allowed amount, co-insurance, copayment, deductible or other  
3843 amount that the insured may be responsible to pay to obtain covered benefits from network or  
3844 out-of-network providers; and (iii) a toll-free telephone number and website established by the  
3845 carrier that enables consumers to request and obtain from a carrier within 2 working days the  
3846 amount the insured will be responsible to pay for a proposed admission, procedure or service that  
3847 is a medically necessary covered benefit, based on the information available to the carrier at the  
3848 time the request is made, including any facility fee, copayment, deductible or other out of pocket  
3849 amount and the actual or maximum estimated allowed amount and co-insurance, for any covered  
3850 health care benefits; provided, that the insured shall not be required to pay more than the  
3851 disclosed amounts for the covered health care benefits; provided, however, that nothing in this  
3852 section shall prevent carriers from imposing cost sharing requirements disclosed in the insured's  
3853 evidence of coverage for unforeseen services that arise out of the proposed admission, procedure  
3854 or service;

3855 (4) the locations where, and the manner in which, health care services and other benefits  
3856 may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or  
3857 service that is a medically necessary covered benefit is not available to an insured within the  
3858 carrier's network, the carrier shall cover the out-of-network admission, procedure or service and  
3859 the insured will not be responsible to pay more than the amount which would be required for

3860 similar admissions, procedures or services offered within the carrier's network; and (ii) an  
3861 explanation that whenever a location is part of the carrier's network, that the carrier shall cover  
3862 medically necessary covered benefits delivered at that location and the insured shall not be  
3863 responsible to pay more than the amount required for network services even if part of the  
3864 medically necessary covered benefits are performed by out-of-network providers unless the  
3865 insured has a reasonable opportunity to choose to have the service performed by a network  
3866 provider;

3867 SECTION 138. Clause (1) of subsection (a) of section 7 of said chapter 176O, as so  
3868 appearing, is hereby amended by striking out, in lines 18 and 19, the words "6 of chapter 118G"  
3869 and inserting in place thereof the following words:- 11 of chapter 12C.

3870 SECTION 139. Said clause (1) of said subsection (a) of said section 7 of said chapter  
3871 176O, as so appearing, is hereby further amended by striking out, in lines 20 and 21, the words  
3872 "6 of said chapter 118G" and inserting in place thereof the following words:- 11 of said chapter  
3873 12C.

3874 SECTION 140. Subsection (c) of section 9A of said chapter 176O, as so appearing, is  
3875 hereby amended by striking out, in line 25, the words "6 of chapter 118G" and inserting in place  
3876 thereof the following words:- 11 of chapter 12C; and.

3877 SECTION 141. Said section 9A of said chapter 176O, as so appearing, is hereby further  
3878 amended by adding the following 2 subsections:-

3879 (d) limits the ability of either the carrier or the health care provider from disclosing the  
3880 allowed amount and fees of services to an insured or insured's treating health care provider.

3881 (e) limits the ability of either the carrier or the health care provider from disclosing out-  
3882 of-pocket costs to an insured.

3883 SECTION 142. Subsection (a) of section 10 of said chapter 176O, as so appearing, is  
3884 hereby amended by striking out, in line 2, the word “health”.

3885 SECTION 143. Said subsection (a) of said section 10 of said chapter 176O, as so  
3886 appearing, is hereby further amended by inserting after the word “group”, in line 2, the following  
3887 words:- or registered provider organization.

3888 SECTION 144. Section 12 of said chapter 176O, as so appearing, is hereby amended by  
3889 striking out subsection (a) and inserting in place thereof the following subsection:-

3890 (a) Utilization review conducted by a carrier or a utilization review organization shall be  
3891 conducted under a written plan, under the supervision of a physician and staffed by appropriately  
3892 trained and qualified personnel and shall include a documented process to: (i) review and  
3893 evaluate its effectiveness; (ii) ensure the consistent application of utilization review criteria; and  
3894 (iii) ensure the timeliness of utilization review determinations. The disclosure of utilization  
3895 review criteria required by this section shall not apply to licensed, proprietary criteria purchased  
3896 by a carrier or utilization review organization.

3897 A carrier or utilization review organization shall adopt utilization review criteria and  
3898 conduct all utilization review activities under said criteria. The criteria shall be, to the maximum  
3899 extent feasible, scientifically derived and evidence-based, and developed with the input of  
3900 participating physicians, consistent with the development of medical necessity criteria under  
3901 section 16. Utilization review criteria shall be applied consistently by a carrier or a utilization  
3902 review organization and made easily accessible and up-to-date on a carrier or utilization review

3903 organization's website to subscribers, health care providers and the general public. If a carrier or  
3904 utilization review organization intends either to implement a new preauthorization requirement  
3905 or restriction or amend an existing requirement or restriction, the carrier or utilization review  
3906 organization shall ensure that the new or amended requirement or restriction shall not be  
3907 implemented unless the carrier's or utilization review organization's website has been updated to  
3908 reflect the new or amended requirement or restriction.

3909           Adverse determinations rendered by a program of utilization review or other denials of  
3910 requests for health services, shall be made by a person licensed in the appropriate specialty  
3911 related to such health service and, if applicable, by a provider in the same licensure category as  
3912 the ordering provider.

3913           SECTION 145. Said section 12 of said chapter 176O, as so appearing, is hereby further  
3914 amended by adding the following subsection:-

3915           (f) Upon request by an insured or insured's treating health care provider, a carrier or  
3916 utilization review organization shall make a determination regarding whether a proposed  
3917 admission, procedure or service is medically necessary within 2 working days of obtaining all  
3918 necessary information, except that a carrier or utilization review organization may choose not to  
3919 perform such a review if the carrier or utilization review organization determines that the  
3920 admission, procedure or service will be covered. Nothing in this subsection shall require a  
3921 treating health care provider to obtain information regarding whether a proposed admission,  
3922 procedure or service is medically necessary on behalf of an insured. Nothing in this subsection  
3923 shall restrict the ability of a carrier or utilization review organization to deny a claim for an  
3924 admission, procedure or service if the admission, procedure or service was not medically

3925 necessary, based on information provided at the time of claim. Nothing in this subsection shall  
3926 restrict the ability of a carrier or utilization review organization to deny a claim for an admission,  
3927 procedure or service if other terms and conditions of coverage are not met at the time of service  
3928 or time of claim.

3929 SECTION 146. Section 15 of said chapter 176O, as so appearing, is hereby amended by  
3930 striking out, in lines 2, 3, 5 and 6, 6, 9, 22, 25, 27, 46 and 47, 47, 49, 52, 60, 71 and 74, the word  
3931 "physician" and inserting in place thereof, in each instance, the following word:- provider.

3932 SECTION 147. Section 16 of said chapter 176O, as so appearing, is hereby amended by  
3933 striking out subsection (b) and inserting in place thereof the following subsection:-

3934 (b) A carrier shall be required to pay for health care services ordered by a treating  
3935 physician or a primary care provider if: (1) the services are a covered benefit under the insured's  
3936 health benefit plan; and (2) the services are medically necessary. A carrier may develop  
3937 guidelines to be used in applying the standard of medical necessity, as defined in this subsection.  
3938 Any such medical necessity guidelines utilized by a carrier in making coverage determinations  
3939 shall be: (i) developed with input from practicing physicians and participating providers in the  
3940 carrier's or utilization review organization's service area; (ii) developed under the standards  
3941 adopted by national accreditation organizations; (iii) updated at least biennially or more often as  
3942 new treatments, applications and technologies are adopted as generally accepted professional  
3943 medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier  
3944 shall consider the individual health care needs of the insured. Any such medical necessity  
3945 guidelines criteria shall be applied consistently by a carrier or a utilization review organization  
3946 and made easily accessible and up-to-date on a carrier or utilization review organization's

3947 website to subscribers, health care providers and the general public. If a carrier or utilization  
3948 review organization intends either to implement a new medical necessity guideline or amend an  
3949 existing requirement or restriction, the carrier or utilization review organization shall ensure that  
3950 the new or amended requirement or restriction shall not be implemented unless the carrier's or  
3951 utilization review organization's website has been updated to reflect the new or amended  
3952 requirement or restriction.

3953 SECTION 148. Subsection (c) of section 21 of said chapter 176O, as so appearing, is  
3954 hereby amended by striking out, in lines 109 and 110, the words "division of health care finance  
3955 and policy for use under section 6 of chapter 118G" and inserting in place thereof the following  
3956 words:- institute of health care finance and policy for use under section 10 of chapter 12C.

3957 SECTION 149. Said section 21 of said chapter 176O, as so appearing, is hereby further  
3958 amended by striking out subsection (d) and inserting in place thereof the following 2  
3959 subsections:-

3960 (d) If a carrier reports a risk-based capital ratio on a combined entity basis under  
3961 subsection (a) that exceeds 700 per cent, the division shall hold a public hearing within 60 days  
3962 of receiving such report. The carrier shall submit testimony on how the carrier will dedicate any  
3963 additional surplus above the 700 per cent level to reducing the cost of health benefit plans or for  
3964 health care quality improvement, patient safety or health cost containment programs consistent  
3965 with the activities of the health care quality and finance authority. The division shall review such  
3966 testimony and issue a final report on the results of the hearing.

3967 (e) The commissioner may waive specific reporting requirements in this section for  
3968 classes of carriers for which the commissioner deems such reporting requirements to be

3969 inapplicable; provided, however, that the commissioner shall provide written notice of any such  
3970 waiver to the joint committee of health care financing and the house and senate committees on  
3971 ways and means.

3972 SECTION 150. Said chapter 176O is hereby amended by adding the following 4  
3973 sections:-

3974 Section 22. No carrier shall enter or renew an agreement or contract with any provider  
3975 organization that is not registered under chapter 12C. Nothing herein shall require a carrier to  
3976 negotiate a network contract with a registered provider organization, or with a registered  
3977 provider organization for all providers that are part of, or represented by, a registered provider  
3978 organization.

3979 Section 23. A provider organization registered under section 10 of chapter 12C which  
3980 utilizes alternative payment methodologies, as defined in section 1 of said chapter 12C, shall  
3981 create an internal appeals process. The internal appeals process shall be available to the public in  
3982 a written format and by request in electronic format. The internal appeals process shall be  
3983 completed in 14 days from the filing of the appeal; provided, that an expedited internal appeal  
3984 process shall be completed in 3 days for a patient with a terminal illness or in emergency  
3985 situations, as defined by regulations promulgated by the department of public health. The  
3986 decision on the appeal shall be in writing and shall notify the patient of the right to file a further  
3987 external appeal.

3988 The department of public health shall establish by regulation an external review process  
3989 for the review of grievances submitted by or on behalf of patients of provider organizations  
3990 registered under section 10 of chapter 12C utilizing alternative payment methodologies. The

3991 process shall specify the maximum amount of time for the completion of a determination and  
3992 review after a grievance is submitted and shall include the right to have benefits continued  
3993 pending appeal. The department shall establish expedited review procedures applicable to  
3994 emergency and urgent care situations Section 24. (a) A payer or any entity acting for a payer  
3995 under contract, when requiring prior authorization for a health care service or benefit, shall use  
3996 and accept only the prior authorization forms designated for the specific types of services and  
3997 benefits developed under subsection (c).

3998 (b) If a payer or any entity acting for a payer under contract fails to use or accept the  
3999 required prior authorization form, or fails to respond within 2 business days after receiving a  
4000 completed prior authorization request from a provider, pursuant to the submission of the prior  
4001 authorization form developed as described in subsection (c), the prior authorization request shall  
4002 be deemed to have been granted.

4003 (c) The division shall develop and implement uniform prior authorization forms for  
4004 different health care services and benefits. The forms shall cover such health care services and  
4005 benefits including, but not limited to, provider office visits, prescription drug benefits, imaging  
4006 and other diagnostic testing, laboratory testing and any other health care services. The division  
4007 shall develop forms for different kinds of services as it deems necessary or appropriate; provided  
4008 that, all payers and any entities acting for a payer under contract shall use the uniform form  
4009 designated by the division for the specific type of service. Six months after the full set of forms  
4010 has been developed, every provider shall use the appropriate uniform prior authorization form to  
4011 request prior authorization for coverage of the health care service or benefit and every payer or  
4012 any entity acting for a payer under contract shall accept the form as sufficient to request prior  
4013 authorization for the health care service or benefit.

4014 (d) The prior authorization forms developed under subsection (c) shall:

4015 (1) not exceed 2 pages;

4016 (2) be made electronically available; and

4017 (3) be capable of being electronically accepted by the payer after being

4018 completed.

4019 (e) The division, in developing the forms, shall:

4020 (1) seek input from interested stakeholders and shall seek to use forms that have

4021 been mutually agreed upon by payers and providers;

4022 (2) ensure that the forms are consistent with existing prior authorization forms

4023 established by the federal Centers for Medicare and Medicaid Services; and

4024 (3) consider other national standards pertaining to electronic prior authorization.

4025 (f) Nothing in this section shall limit a health plan from requiring prior authorization for

4026 services.

4027 Section 25. The division shall promulgate regulations under which a carrier may move

4028 members into and out of different payment methodologies, including, but not limited to, different

4029 product types, without mutual agreement from the participating provider.

4030 SECTION 151. Section 1 of chapter 176Q of the General Laws, as appearing in the 2010

4031 Official Edition, is hereby amended by inserting after the definition of "connector seal of

4032 approval" the following definition:-

4033        “Dependent”, the spouse and children of any employee if such persons would qualify for  
4034 dependent status under the Internal Revenue Code or for whom a support order could be granted  
4035 under chapters 208, 209 or 209C.

4036        SECTION 152. Said section 1 of said chapter 176Q, as so appearing, is hereby further  
4037 amended by striking out the definition of “division”.

4038        SECTION 153. Said section 1 of said chapter 176Q, as so appearing, is hereby further  
4039 amended by inserting after the definition of “eligible small groups” the following 2 definitions:-

4040        “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which  
4041 ends in the calendar year by which it is identified.

4042        “Free care”, the following medically necessary services provided to individuals  
4043 determined to be financially unable to pay for their care, in whole or in part, under applicable  
4044 regulations of the connector: (1) services provided by acute hospitals; (2) services provided by  
4045 community health centers; and (3) patients in situations of medical hardship in which major  
4046 expenditures for health care have depleted or can reasonably be expected to deplete the financial  
4047 resources of the individual to the extent that medical services cannot be paid, as determined by  
4048 regulations of the connector.

4049        SECTION 154. Said section 1 of said chapter 176Q, as so appearing, is hereby further  
4050 amended by inserting after the definition of “mandated benefits” the following 2 definitions:-

4051        “Medically necessary services”, medically necessary inpatient and outpatient services as  
4052 mandated under Title XIX of the Federal Social Security Act; provided, that “medically  
4053 necessary services” shall not include: (1) non-medical services, such as social, educational and

4054 vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone  
4055 conversations and consultations; (5) court testimony; (6) research or the provision of  
4056 experimental or unproven procedures including, but not limited to, treatment related to sex-  
4057 reassignment surgery, and pre-surgery hormone therapy; and (7) the provision of whole blood;  
4058 and provided, however, that administrative and processing costs associated with the provision of  
4059 blood and its derivatives shall be payable.

4060 "Non-providing employer", an employer of a state-funded employee, as defined in this  
4061 section; provided, however, that the term "non-providing employer" shall not include:—

4062 (i) an employer who complies with chapter 151F for such employee;  
4063 (ii) an employer that is signatory to or obligated under a negotiated, bona fide  
4064 collective bargaining agreement between such employer and bona fide employee representative  
4065 which agreement governs the employment conditions of such person receiving free care;  
4066 (iii) an employer who participates in the insurance reimbursement program; or  
4067 (iv) an employer that employs not more than 10 employees.

4068 For the purposes of this definition, an employer shall not be considered to pay for or  
4069 arrange for the purchase of health care services provided by acute hospitals and ambulatory  
4070 surgical centers by making or arranging for any payments to the uncompensated care pool.

4071 SECTION 155. Said section 1 of said chapter 176Q, as so appearing, is hereby further  
4072 amended by inserting after the definition of "participating institution" the following definition:-

4073 "Payments from non-providing employers", all amounts paid to the Uncompensated Care  
4074 Trust Fund or the General Fund or any successor fund by non-providing employers.

4075 SECTION 156. Said section 1 of said chapter 176Q, as so appearing, is hereby further

4076 amended by inserting after the definition of “rating factor” the following definition:-

4077 “State-funded employee”, any employed person, or dependent of such person, who

4078 receives, on more than 3 occasions during any hospital fiscal year, health services paid for as free

4079 care; or any employed persons, or dependents of such persons, of a company that has 5 or more

4080 occurrences of health services paid for as free care by all employees in aggregate during any

4081 fiscal year; provided that an occurrence shall include all healthcare related services incurred

4082 during a single visit to a health care professional.

4083 SECTION 157. Said section 1 of said chapter 176Q, as so appearing, is hereby further

4084 amended by inserting after the definition of “sub-connector” the following definition:-

4085 “Uninsured patient”, a patient who is not covered by a health insurance plan, a self-

4086 insurance health plan or a medical assistance program.

4087 SECTION 158. Subsection (m) of section 3 of chapter 176Q of the General Laws, as

4088 appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 84 and 85, the

4089 words “the board deems necessary to implement chapters 111M, 118G and 118H” and inserting

4090 in place thereof the following words:- , departments, commissions, authorities or political

4091 subdivisions the board considers necessary or appropriate to implement chapters 111M, 118E,

4092 118H and this chapter.

4093 SECTION 159. Said section 3 of said chapter 176 Q, as so appearing, is hereby further

4094 amended by adding the following subsection:-

4095 (u) to enter into contracts or agreements, at the board's discretion, with state departments,  
4096 agencies, commissions, authorities, political subdivisions or any individuals, groups, non-profit  
4097 or not-for-profit corporations, organizations or associations that are seeking affordable health  
4098 insurance; provided further, that the connector shall serve as an agent or advisor to assist with or  
4099 procure health insurance for said entities or persons. The board shall give preference to assisting  
4100 non-profit or not-for-profit corporations or individuals, groups, organizations or associations  
4101 seeking the connector's assistance for populations that have been historically uninsured or  
4102 underinsured.

4103 SECTION 160. Chapter 176Q of the General Laws is hereby amended by striking out  
4104 section 7A and inserting in place thereof the following section:-

4105 Section 7A. (a) There shall be a small group wellness incentive pilot program to expand  
4106 the prevalence of employee wellness initiatives by small businesses. The program shall be  
4107 administered by the board of the connector, in consultation with the department of public health.  
4108 The program shall provide subsidies and technical assistance for eligible small groups to  
4109 implement evidence-based employee health and wellness programs to improve employee health,  
4110 decrease employer health costs and increase productivity.

4111 (b) An eligible small group shall be qualified to participate in the program if:

4112 (1) the eligible small group purchases group coverage through the connector;  
4113 (2) the eligible small group enrolls in an evidence-based, employee wellness  
4114 program offered through the connector;

4115 (3) the eligible small group meets certain minimum criteria, as determined by the  
4116 connector board; and

4117 (4) the eligible small group meets certain minimum employee participation  
4118 requirements in the qualified wellness program, as determined by the connector board, in  
4119 collaboration with the department of public health.

4120 (c) For eligible small groups participating in the program, the connector shall provide an  
4121 annual subsidy not to exceed 15 per cent of eligible employer health care costs as calculated by  
4122 the connector board. If the director determines that funds are insufficient to meet the projected  
4123 costs of enrolling new eligible employers, the director shall impose a cap on enrollment in the  
4124 program.

4125 (d) The connector shall report annually to the joint committee on community  
4126 development and small business, the joint committee on health care financing and the house and  
4127 senate committees on ways and means on the enrollment in the small business wellness incentive  
4128 program and evaluate the impact of the program on expanding wellness initiatives for small  
4129 groups.

4130 (e) The connector shall promulgate regulations to implement this section.

4131 SECTION 161. Said chapter 176Q is hereby amended by adding the following 2  
4132 sections:-

4133 Section 17. (a) The connector shall prepare a form, to be called the employer health  
4134 insurance responsibility disclosure, on which an employer shall report whether it is in  
4135 compliance with chapter 151F and any other information required by the connector relative to

4136 section 18 and paragraph (4) of subsection (a) of section 69 of chapter 118E. The form shall be  
4137 completed, signed and returned to the institute by every employer with 11 or more full-time  
4138 equivalent employees.

4139 (b) The connector shall prepare a form, to be called the employee health insurance  
4140 responsibility disclosure, on which an employee of employers with 11 or more full-time  
4141 equivalent employees who declines an employer-sponsored health plan shall report whether the  
4142 employee has an alternative source of health insurance coverage. The form shall be completed  
4143 and signed by the employee and shall be retained by the employer for 3 years. The institute may  
4144 request a copy of the signed employee form.

4145 (c) Information that identifies individual employees by name or health insurance status  
4146 shall not be a public record, but the information shall be exchanged with the department of  
4147 revenue, the commonwealth health insurance connector authority and the health care access  
4148 bureau in the division of insurance under an interagency services agreement to enforce this  
4149 section, sections 3 to 7A, inclusive and sections 3, 6B and 18B of chapter 118H. An employer  
4150 who knowingly falsifies or fails to file with the connector any information required by this  
4151 section or by any regulation promulgated by the connector shall be punished by a fine of not less  
4152 than \$1,000 not more than \$5,000.

4153 Section 18. (a) The connector shall, upon verification of the provision of services and  
4154 costs to a state-funded employee, assess a free rider surcharge on the non-providing employer  
4155 under regulations promulgated by the connector.

4156 (b) The amount of the free rider surcharge on non-providing employers shall be  
4157 determined by the connector under regulations promulgated by the connector, and assessed by

4158 the connector not later than 3 months after the end of each hospital fiscal year, with payment by  
4159 non-providing employers not later than 180 days after the assessment. The amount charged by  
4160 the connector shall be greater than 10 per cent but not greater than 100 per cent of the cost to the  
4161 state of the services provided to the state-funded employee, considering all payments received by  
4162 the state from other financing sources for free care; provided that the “cost to the state” for  
4163 services provided to any state-funded employee may be determined by the connector as a  
4164 percentage of the state’s share of aggregate costs for health services. The free rider surcharge  
4165 shall only be triggered upon incurring \$50,000 or more, in any hospital fiscal year, in free care  
4166 services for any employer’s employees, or dependents of such persons, in aggregate, regardless  
4167 of how many state-funded employees are employed by that employer.

4168 (c) The formula for assessing free rider surcharges on non-providing employers shall be  
4169 set forth in regulations promulgated by the connector that shall be based on factors including, but  
4170 not limited to: (i) the number of incidents during the past year in which employees of the non-  
4171 providing employer received services reimbursed by the health safety net office under section 69  
4172 of chapter 118E; (ii) the number of persons employed by the non-providing employer; (iii) the  
4173 proportion of employees for whom the non-providing employer provides health insurance.

4174 (d) If a state-funded employee is employed by more than 1 non-providing employer at the  
4175 time the employee receives services, the connector shall assess a free rider surcharge on each  
4176 said employer consistent with the formula established by the connector under this section.

4177 (e) The connector shall specify by regulation appropriate mechanisms for implementing  
4178 free rider surcharges on non-providing employers. Said regulations shall include, but not be  
4179 limited to, the following:—

4180 (i) appropriate mechanisms that provide for determination and payment of  
4181 surcharge by a non-providing employer including requirements for data to be submitted by  
4182 employers, employees, acute hospitals and ambulatory surgical centers, and other persons; and  
4183 (ii) penalties for nonpayment or late payment by the non-providing employer,  
4184 including assessment of interest on the unpaid liability at a rate not to exceed an annual  
4185 percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per  
4186 month.

4187 (f) All surcharge payments made under this section shall be deposited into the  
4188 Commonwealth Care Trust Fund, established by section 2000 of chapter 29.

4189 (g) A non-providing employer's liability to that fund shall in the case of a transfer of  
4190 ownership be assumed by the successor in interest to the non-providing employer's.

4191 (h) If a non-providing employer fails to file any data, statistics or schedules or other  
4192 information required under this chapter or by any regulation promulgated by the connector, the  
4193 connector shall provide written notice of the required information. If the employer fails to  
4194 provide information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be  
4195 subject to a civil penalty of not more than \$5,000 for each week on which such violation occurs  
4196 or continues, which penalty may be assessed in an action brought on behalf of the  
4197 commonwealth in any court of competent jurisdiction.

4198 (i) The attorney general shall bring any appropriate action, including injunctive relief, as  
4199 may be necessary for the enforcement of this section.

4200 (j) No employer shall discriminate against any employee on the basis of the employee's  
4201 receipt of free care, the employee's reporting or disclosure of the employer's identity and other  
4202 information about the employer, the employee's completion of a Health Insurance Responsibility  
4203 Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed  
4204 against the employer in relation to the employee. Violation of this subsection shall constitute a  
4205 per se violation of chapter 93A.

4206 (k) A hospital, surgical center, health center or other entity that provides health safety net  
4207 services shall provide an uninsured patient with written notice of the criminal penalties for  
4208 committing fraud in connection with the receipt of health safety net services. The connector shall  
4209 promulgate a standard written notice form to be made available to health care providers in  
4210 English and foreign languages. The form shall further include written notice of every employee's  
4211 protection from employment discrimination under this section.

4212 SECTION 162. The General Laws are hereby amended by inserting, after chapter 176R  
4213 the following 2 chapters:

4214 CHAPTER 176S

4215 COMMONWEALTH HEALTH CARE QUALITY AND FINANCE AUTHORITY

4216 Section 1. As used in this chapter the following words shall, unless the context clearly  
4217 requires otherwise, have the following meanings:-

4218 "Actual economic growth benchmark," the actual annual percentage change in the per  
4219 capita state's gross state product, excluding the impact of business cycles, as established under  
4220 section 7H½ of chapter 29.

4221        “Acute hospital,” the teaching hospital of the University of Massachusetts Medical  
4222 School and any hospital licensed under section 51 of chapter 111 and which contains a majority  
4223 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of  
4224 public health.

4225        “Alternative payment contract”, any contract between a provider or provider organization  
4226 and a public health care payer or a private health care payer which utilizes alternative payment  
4227 methodologies.

4228        “Alternative payment methodologies”, methods of payment that are not directly fee-for-  
4229 service reimbursement for services; provided, that “alternative payment methodologies” may  
4230 include, but not be limited to, global payments, shared savings arrangements, bundled payments  
4231 and episodic payments.

4232        “Authority”, the commonwealth health care quality and finance authority.

4233        “Beacon ACO”, a certification given by the board of the authority to indicate that a  
4234 provider organization meets certain standards regarding quality, cost containment and patient  
4235 protection.

4236        “Board”, the board of the commonwealth health care quality and finance authority,  
4237 established by section 2.

4238        “Business entity”, a corporation, association, partnership, limited liability company,  
4239 limited liability partnership or other legal entity.

4240        “Carrier,” an insurer licensed or otherwise authorized to transact accident or health  
4241 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter

4242 176A; a nonprofit medical service corporation organized under chapter 176B; a health  
4243 maintenance organization organized under chapter 176G; and an organization entering into a  
4244 preferred provider arrangement under chapter 176I, but not including an employer purchasing  
4245 coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or  
4246 affiliated corporations of the employer; provided that, unless otherwise noted, the term "carrier"  
4247 shall not include any entity to the extent it offers a policy, certificate or contract that provides  
4248 coverage solely for dental care services or visions care services.

4249 "Facility," a licensed institution providing health care services or a health care setting,  
4250 including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical  
4251 or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory  
4252 and imaging centers and rehabilitation and other therapeutic health settings.

4253 "Fee-for-service", a form of contract under which a provider or provider organization is  
4254 paid for discrete and separate units of service and each provider is separately reimbursed for each  
4255 discrete service rendered to a patient; provided, however, that up to 20 per cent of total  
4256 reimbursement under such contracts may depend on the achievement of certain targets of  
4257 performance or conduct.

4258 "Institute", the institute of health care finance and policy established in chapter 12C.

4259 "Health benefit plan", any individual, general, blanket or group policy of health, accident  
4260 and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service  
4261 plan issued by a non-profit hospital service corporation under chapter 176A; a group medical  
4262 service plan issued by a non-profit medical service corporation under chapter 176B; a group  
4263 health maintenance contract issued by a health maintenance organization under chapter 176G; a

4264 coverage for young adults health insurance plan under section 10 of chapter 176J; provided that  
4265 “health benefit plan” shall not include accident only, credit-only, limited scope vision or dental  
4266 benefits if offered separately, hospital indemnity insurance policies if offered as independent,  
4267 non-coordinated benefits which for the purposes of this chapter shall mean policies issued under  
4268 chapter 175 which provide a benefit not to exceed \$500 per day, as adjusted on an annual basis  
4269 by the amount of increase in the average weekly wages in the commonwealth as defined in  
4270 section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an  
4271 insured, on the basis of a hospitalization of the insured or a dependent, disability income  
4272 insurance, coverage issued as a supplement to liability insurance, specified disease insurance that  
4273 is purchased as a supplement and not as a substitute for a health plan and meets any requirements  
4274 the commissioner of insurance by regulation may set, insurance arising out of a workers  
4275 compensation law or similar law, automobile medical payment insurance, insurance under which  
4276 benefits are payable with or without regard to fault and which is statutorily required to be  
4277 contained in a liability insurance policy or equivalent self insurance, long-term care if offered  
4278 separately, coverage supplemental to the coverage provided under 10 U.S.C. section 55 if offered  
4279 as a separate insurance policy, or any policy subject to chapter 176K or any similar policies  
4280 issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans;  
4281 provided, further that “health benefit plan” shall not include a health plan issued, renewed or  
4282 delivered within or without the commonwealth to an individual who is enrolled in a qualifying  
4283 student health insurance program under section 18 of chapter 15A which shall be governed by  
4284 said chapter 15A; provided, further that the authority may by regulation define other health  
4285 coverage as a health benefit plan for the purposes of this chapter.

4286        “Health care cost growth benchmark,” the projected annual percentage change in total

4287 health care expenditures in the commonwealth, as established in section 5.

4288        “Health care entity”, a provider, provider organization or carrier.

4289        “Health care professional,” a physician or other health care practitioner licensed,

4290 accredited or certified to perform specified health services consistent with law.

4291        “Health care services,” services for the diagnosis, prevention, treatment, cure or relief of

4292 a physical, behavioral, substance use disorder or mental health condition, illness, injury or

4293 disease.

4294        “Health status adjusted total medical expenses”, the total cost of care for the patient

4295 population associated with a provider group based on allowed claims for all categories of

4296 medical expenses and all non-claims related payments to providers, adjusted by health status and

4297 expressed on a per member per month basis, as calculated under section 9 of chapter 12C.

4298        “Major service category,” a set of service categories to be established by regulation,

4299 which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii)

4300 outpatient and ambulatory services, by categories as defined by the Centers for Medicare and

4301 Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all

4302 other” outpatient and ambulatory services that do not fall within a defined category; (iii)

4303 behavioral substance use disorder and mental health services by categories as defined by the

4304 Centers for Medicare and Medicaid, or as established by regulation; (iv) professional services, by

4305 categories as defined by the Centers for Medicare and Medicaid, or as established by regulation;

4306 and (v) sub-acute services, by major service line or clinical offering, as defined by regulation.

4307       “Medicaid program”, the medical assistance program administered by the division of  
4308    medical assistance under chapter 118E and in accordance with Title XIX of the Federal Social  
4309    Security Act or any successor statute.

4310       “Medicare program”, the medical insurance program established by Title XVIII of the  
4311    Social Security Act.

4312       “Net cost of private health insurance,” the difference between health premiums earned  
4313    and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as  
4314    included in medical loss ratio regulations promulgated by the division of insurance; (ii) net  
4315    additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise  
4316    defined by regulations promulgated by the institute under chapter 12C.

4317       “Performance improvement plan,” a plan submitted to the authority by a carrier, a  
4318    provider or a provider organization under section 7, which shall be kept confidential by the board  
4319    and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4  
4320    or chapter 66.

4321       “Projected economic growth benchmark,” the long-term average projected percentage  
4322    change in the per capita state’s gross state product, excluding the impact of business cycles, as  
4323    established under section 7H½ of chapter 29.

4324       “Provider,” a health care professional or a facility.

4325       “Provider organization,” any corporation, partnership, business trust, association or  
4326    organized group of persons whether incorporated or not that consists of or represents 1 or more  
4327    providers in contracting with carriers for the payments the provider or providers receive for the

4328 provision of health care services or as further defined in regulations promulgated by the institute  
4329 of health care finance and policy under chapter 12C; provided, that "provider organization" shall  
4330 include, but not be limited to, physician organizations, physician-hospital organizations,  
4331 independent practice associations, accountable care organizations, provider networks and any  
4332 other organization that contracts with carriers for payment for health care services.

4333 "Specialty hospital," an acute hospital which qualifies for an exemption from the  
4334 Medicare prospective payment system regulations or any acute hospital which limits its  
4335 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to  
4336 children or patients under obstetrical care.

4337 "Total health care expenditures", the annual per capita sum of all health care expenditures  
4338 in the commonwealth from public and private sources, including: (i) all categories of medical  
4339 expenses and all non-claims related payments to providers, as included in the health status  
4340 adjusted total medical expenses reported by the institute under subsection (d) of section 9 of  
4341 chapter 12C; (ii) all patient cost-sharing amounts, such as, deductibles and copayments; and (iv)  
4342 the net cost of private health insurance, or as otherwise defined by the institute in regulations  
4343 promulgated under said chapter 12C.

4344 Section 2. (a) There shall be a body politic and corporate and a public instrumentality to  
4345 be known as the commonwealth health care quality and finance authority, which shall be an  
4346 independent public entity not subject to the supervision and control of any other executive office,  
4347 department, commission, board, bureau, agency or political subdivision of the commonwealth  
4348 except as specifically provided in any general or special law. The exercise by the authority of the  
4349 powers conferred by this chapter shall be considered to be the performance of an essential public

4350 function. The purpose of the authority shall be to set health care cost containment goals for the  
4351 commonwealth and to foster innovative health care delivery and payment models that lower  
4352 health care cost growth while improving the quality of patient care.

4353 (b) There shall be a board, with duties and powers established by this chapter, that shall  
4354 govern the authority. The authority's board shall consist of 11 members: the secretary of  
4355 administration and finance, ex officio; the secretary of health and human services, ex officio; the  
4356 secretary of housing and economic development, ex officio; 1 other member appointed by the  
4357 governor whom shall be an expert in health care delivery and payment models; 3 members  
4358 appointed by the attorney general, 1 of whom shall be a health economist, 1 of whom shall  
4359 represent the interests of businesses and 1 of whom shall have experience in the administration  
4360 of a health care provider organization; 3 members appointed by the state auditor, 1 of whom  
4361 shall be an expert in behavioral substance use disorder and mental health services and behavioral  
4362 substance use disorder and mental health reimbursement systems, 1 of whom shall be a  
4363 representative of a health consumer organization and 1 of whom shall be a representative of  
4364 organized labor. The governor, attorney general and the auditor shall, by majority vote, jointly  
4365 appoint 1 member who is an expert in health care finance and policy in the commonwealth, to act  
4366 as the chair. All members shall serve a term of 3 years, but a member appointed to fill a vacancy  
4367 shall serve only for the unexpired term. An appointed member of the board shall be eligible for  
4368 reappointment. The board shall annually elect 1 of its members to serve as the vice-chairperson.  
4369 Each member of the board serving ex officio may appoint a designee under section 6A of chapter  
4370 30.

4371 (c) A member of the board shall not be employed by, a consultant to, a member of the  
4372 board of directors of, affiliated with, have a financial stake in or otherwise be a representative of  
4373 a health care entity while serving on the board.

4374 (d) Six members of the board shall constitute a quorum and the affirmative vote of 6  
4375 members of the board shall be necessary and sufficient for any action taken by the board. No  
4376 vacancy in the membership of the board shall impair the right of a quorum to exercise all the  
4377 rights and duties of the connector. Members shall serve without pay but shall be reimbursed for  
4378 actual expenses necessarily incurred in the performance of their duties. The chairperson of the  
4379 board shall report to the governor and to the general court not less frequently than annually.

4380 (e) Any action of the authority may take effect immediately and need not be published or  
4381 posted unless otherwise provided by law. Meetings of the board shall be subject to sections 18 to  
4382 25, inclusive, of chapter 30A; but, said sections 18 to 25, inclusive, shall not apply to any  
4383 meeting of members of the board serving ex officio in the exercise of their duties as officers of  
4384 the commonwealth if no matters relating to the official business of the authority are discussed  
4385 and decided at the meeting. The authority shall be subject to all other provisions of said chapter  
4386 30A and records pertaining to the administration of the authority shall be subject to section 42 of  
4387 chapter 30 and section 10 of chapter 66. All moneys of the authority shall be considered to be  
4388 public funds for purposes of chapter 12A. The operations of the authority shall be subject to  
4389 chapter 268A and chapter 268B.

4390 (f) The chairperson shall hire an executive director to supervise the administrative affairs  
4391 and general management and operations of the authority and also serve as secretary of the  
4392 authority, ex officio. The executive director shall receive a salary commensurate with the duties

4393 of the office. The executive director may appoint other officers and employees of the authority  
4394 necessary to the functioning of the authority. Sections 9A, 45, 46 and 46C of chapter 30, chapter  
4395 31 and chapter 150E shall not apply to the executive director of the authority. The executive  
4396 director shall, with the approval of the board:

- 4397 (i) plan, direct, coordinate and execute administrative functions in conformity
- 4398 with the policies and directives of the board;
- 4399 (ii) employ professional and clerical staff as necessary;
- 4400 (iii) report to the board on all operations under the executive director's control
- 4401 and supervision;
- 4402 (iv) prepare an annual budget and manage the administrative expenses of the
- 4403 authority; and
- 4404 (v) undertake any other activities necessary to implement the powers and duties
- 4405 under this chapter.

4406 Section 3. The board of the authority shall set health care cost containment goals for the  
4407 commonwealth and foster the innovation of health care delivery and payment models that lower  
4408 health care cost growth while improving the quality of patient care. The board shall have all  
4409 powers necessary or convenient to carry out and effectuate its purposes including, but not limited  
4410 to, the power to:

- 4411 (a) to develop a plan of operation for the authority, which shall include, but not be limited
- 4412 to:
  - 4413 (1) establishing procedures for operations of the authority;

4414 (2) establishing procedures for communications with the executive director;

4415 (3) establishing procedures for setting an annual health care cost growth

4416 benchmark;

4417 (4) holding annual hearings concerning the growth in total health care

4418 expenditures relative to the health care cost growth benchmark, including an examination of

4419 health care provider, provider organization and payer costs, prices and health status adjusted total

4420 medical expense trends;

4421 (5) providing an annual report on recommendations for strategies to meet future

4422 annual health care cost growth benchmarks and to promote an efficient health delivery system;

4423 (6) establishing procedures that, in the event the annual health care cost growth

4424 benchmark is exceeded, require certain health care entities to file a performance improvement

4425 plan and the procedures for approving said plan;

4426 (7) establishing procedures for monitoring compliance and implementation by a

4427 health care entity of a performance improvement plan, including standards to ascertain whether a

4428 health care entity has failed to implement a performance improvement plan in good faith;

4429 (8) establishing procedures and developing criteria for the certification of certain

4430 provider organizations as Beacon ACOs, based on standards related to cost containment, quality

4431 improvement and patient protections;

4432 (9) establishing procedures to decertify certain provider organizations as Beacon

4433 ACOs;

4434 (10) developing best practices and standards for alternative payment methodologies to be adopted by the office of Medicaid, the group insurance commission and other state-funded health insurance programs;

4437 (11) fostering health care innovation by identifying, developing, supporting and evaluating health care delivery and payment reform models and best practices, in consultation with health care entities, that reduce health care cost growth while improving the quality of patient care; and

4441 (12) administering the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of 2011, to support the activities of the authority;

4443 (b) to adopt by-laws for the regulation of its affairs and the conduct of its business;

4444 (c) to adopt an official seal and alter the same;

4445 (d) to maintain an office at such place or places in the commonwealth as it may designate;

4447 (e) to sue and be sued in its own name, plead and be impleaded;

4448 (f) to establish lines of credit, and establish 1 or more cash and investment accounts to receive payments for services rendered, appropriations from the commonwealth and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974;

4452 (g) to approve the use of its trademarks, brand names, seals, logos and similar instruments by participating carriers, employers or organizations; and

4454 (h) to enter into interdepartmental agreements with the institute of health care finance and  
4455 policy, the executive office of health and human services, the division of insurance and any other  
4456 state agencies the board considers necessary.

4457 Section 4. There shall be an advisory board to the authority. The advisory board shall  
4458 advise on the overall operation and policy of the authority. The advisory board shall consist of 7  
4459 ex-officio members, including the state auditor, the inspector general, the attorney general, the  
4460 commissioner of insurance, the executive director of the institute of health care finance and  
4461 policy, the commissioner of public health and the executive director of the group insurance  
4462 commission, or their designees; and 15 additional members to be appointed by the governor, 1 of  
4463 whom shall be a representative of a health care quality improvement organization recognized by  
4464 the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of  
4465 the Institute for Healthcare Improvement recommended by the organization's board of directors,  
4466 1 of whom shall be a representative of the Massachusetts chapter of the National Association of  
4467 Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts  
4468 Association of Health Underwriters, Inc., 1 of whom shall be a representative of the  
4469 Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy  
4470 from a foundation or academic institution, 1 of whom shall be a representative of a non-  
4471 governmental purchaser of health insurance, 1 of whom shall be an organization representing the  
4472 interests of small businesses with fewer than 50 employees, 1 of whom shall be an organization  
4473 representing the interests of large businesses with 50 or more employees, 1 of whom shall be a  
4474 physician licensed to practice in the commonwealth and 1 of whom shall be a non-physician  
4475 health care professional licensed to practice in the commonwealth; 1 of whom shall be an expert  
4476 in racial and ethnic health disparities; 1 of whom shall be a representative of an organization

4477 representing the interests of academic medical centers; 1 of whom shall be a member of  
4478 MassMEDIC; and 1 of whom shall be selected from a list of 2 names provided by the President  
4479 of the Massachusetts AFL-CIO.

4480 Section 5. (a) Not later than April 15 of every year, the board shall establish a health care  
4481 cost growth benchmark for the average growth in total health care expenditures in the  
4482 commonwealth for the next calendar year. The authority shall establish procedures to  
4483 prominently publish the annual health care cost growth benchmark on the authority's website.

4484 (b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal  
4485 to the economic growth benchmark established under section 7H½ of chapter 29, plus 0.5%.

4486 (c) For calendar years 2016 and thereafter, the health care cost growth benchmark shall  
4487 be equal to the economic growth benchmark established under section 7H½ of chapter 29.

4488 Section 6. (a) Not later than October 1 of every year, the board shall hold public hearings based  
4489 on the report submitted by the institute under section 15 of chapter 12C comparing the growth in  
4490 total health care expenditures to the health care cost growth benchmark for the previous calendar  
4491 year. The hearings shall examine health care provider, provider organization and private and  
4492 public health care payer costs, prices, and cost trends, with particular attention to factors that  
4493 contribute to cost growth within the commonwealth's health care system. The attorney general  
4494 may intervene in such hearings.

4495 (b) Public notice of any hearing shall be provided at least 60 days in advance.

4496 (c) The authority shall identify as witnesses for the public hearing a representative sample  
4497 of providers, provider organizations, payers and others, including: (i) at least 3 academic medical

4498 centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii)  
4499 at least 3 disproportionate share hospitals, including the 2 hospitals whose largest per cent of  
4500 gross patient service revenue is attributable to Title XVIII and XIX of the federal Social Security  
4501 Act or other governmental payers; (iii) community hospitals from at least 3 separate regions of  
4502 the state; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the  
4503 state; (v) community health centers from at least 3 separate regions of the state; (vi) the 5 private  
4504 health care payers with the highest enrollments in the state; (vii) any managed care organization  
4505 that provides health benefits under Title XIX or under the commonwealth care health insurance  
4506 program; (viii) the group insurance commission; (ix) at least 3 municipalities that have adopted  
4507 chapter 32B; (x) at least 3 provider organizations, at least 1 of which shall be a physician  
4508 organization and at least 1 of which has been certified as a Beacon ACO; and (xi) any witness  
4509 identified by the attorney general or the institute of health care finance and policy.

4510 (d) Witnesses shall provide testimony under oath and subject to examination and cross  
4511 examination by the board, the executive director of the institute and the attorney general at the  
4512 public hearing in a manner and form to be determined by the board, including without limitation:  
4513 (i) in the case of providers and provider organizations, testimony concerning payment systems,  
4514 care delivery models, payer mix, cost structures, administrative and labor costs, capital and  
4515 technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization  
4516 trends, relative price, quality improvement and care-coordination strategies, investments in  
4517 health information technology, the relation of private payer reimbursement levels to public payer  
4518 reimbursements for similar services, efforts to improve the efficiency of the delivery system and  
4519 efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private  
4520 and public payers, testimony concerning factors underlying premium cost and rate increases, the

4521 relation of reserves to premium costs, the payer's efforts to develop benefit design, network  
4522 design and payment policies that enhance product affordability and encourage efficient use of  
4523 health resources and technology including utilization of alternative payment methodologies,  
4524 efforts by the payer to increase consumer access to health care information, efforts by the payer  
4525 to promote the standardization of administrative practices and any other matters as determined  
4526 by the board. The board shall solicit testimony from any payer which has been identified by the  
4527 institute's annual report under section 15 of chapter 12C as (i) paying providers more than 10 per  
4528 cent above or more than 10 percent below the weighted average relative price or (ii) entering into  
4529 alternative payment contracts that vary by more than 10 per cent. Any payer identified by the  
4530 institute's report shall explain the extent of price variation between the payer's participating  
4531 providers and describe any efforts to reduce such price variation.

4532 (e) In the event that the institute's annual report under section 15 of chapter 12C finds  
4533 that the percentage change in total health care expenditures exceeded the health care cost  
4534 benchmark in the previous calendar year, the authority may identify additional witnesses for the  
4535 public hearing. Witnesses shall provide testimony subject to examination and cross examination  
4536 by the board, the executive director of the institute and attorney general at the public hearing in a  
4537 manner and form to be determined by the board, including without limitation: (i) testimony  
4538 concerning unanticipated events that may have impacted the total health care cost expenditures,  
4539 including, but not limited to, a public health crisis such as an outbreak of a disease, a public  
4540 safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity  
4541 or utilization of services; (iii) testimony concerning trends in input cost structures, including, but  
4542 not limited to, the introduction of new pharmaceuticals, medical devices and other health  
4543 technologies; (iv) testimony concerning the cost of providing certain specialty services, including

4544 but not limited to, the provision of health care to children, the provision of cancer-related health  
4545 care and the provision of medical education; (v) testimony related to unanticipated administrative  
4546 costs for carriers, including, but not limited to, costs related to information technology,  
4547 administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related  
4548 to costs due the implementation of state or federal legislation or government regulation; and (vii)  
4549 any other factors that may have led to excessive health care cost growth.

4550 (f) The authority shall compile an annual report concerning spending trends and  
4551 underlying factors, along with any recommendations for strategies to increase the efficiency of  
4552 the health care system. The report shall be based on the authority's analysis of information  
4553 provided at the hearings by providers, provider organizations and insurers, data collected by the  
4554 institutes under sections 9, 10 and 11 of chapter 12C, and any other information the authority  
4555 considers necessary to fulfill its duties under this section, as further defined in regulations  
4556 promulgated by the authority. The report shall be submitted to the chairs of the house and senate  
4557 committees on ways and means, the chairs of the joint committee on health care financing and  
4558 shall be published and available to the public not later than December 31 of each year. The  
4559 report shall include any legislative language necessary to implement the recommendations

4560 Section 7. (a) The authority shall provide confidential notice to health care entities whose  
4561 increase in health status adjusted total medical expense is considered excessive and who threaten  
4562 the ability of the state to meet the health care cost growth benchmark as identified by the institute  
4563 under section 16 of chapter 12C. Such notice shall state that the health care entity has been  
4564 identified as having an excessive increase in health status adjusted total medical expense.

4565 (b) For calendar year 2015, in the event that the institute's annual report under section 15  
4566 of chapter 12C finds that average percentage change in cumulative total health care expenditures  
4567 from 2012 to 2014 exceeded the average health care cost growth benchmark from 2012 to 2014,  
4568 and in order to support the state's efforts to meet future health care cost growth benchmarks, as  
4569 established in section 5, the authority shall establish procedures to assist health care entities to  
4570 improve efficiency and reduce cost growth through the requirement of certain health care entities  
4571 to file and implement a performance improvement plan.

4572 Beginning in calendar year 2016, in the event that the institute's annual report under said  
4573 section 15 of said chapter 12C finds that percentage change in total health care expenditures  
4574 exceeded the health care cost growth benchmark in the previous calendar year, and in order to  
4575 support the state's efforts to meet future health care cost growth benchmarks, as established in  
4576 said section 5, the authority shall establish procedures to assist health care entities to improve  
4577 efficiency and reduce the cost growth through the requirement of certain health care entities to  
4578 file and implement a performance improvement plan.

4579 (c) In addition to the confidential notice provided under subsection (a), the authority may  
4580 provide confidential notice to the health care entity that it will be required to file a performance  
4581 improvement plan. Within 45 days of receiving this notice from the authority, the health care  
4582 entity shall either:

4583 (1) file a confidential performance improvement plan with the authority; or  
4584 (2) file a confidential application with the authority to waive or extend the  
4585 requirement to file a performance improvement plan. The health care entity may file any  
4586 documentation or supporting evidence with the authority to support the health care entity's

4587 application to waive or extend the requirement to file a performance improvement plan. The  
4588 authority shall require the health care entity to submit any other relevant information it deems  
4589 necessary in considering the waiver or extension application.

4590 All information submitted shall remain confidential and exempt from disclosure under  
4591 clause Twenty-sixth of section 7 of chapter 4 and chapter 66.

4592 (d) The authority may waive or delay the requirement for a health care entity to file a  
4593 performance improvement plan in response to a waiver or extension request filed under  
4594 paragraph (2) of subsection (c) based on a consideration of the following factors, in light of all  
4595 information received from the health care entity:

4596 (1) the costs, price and utilization trends of the health care entity over time, and  
4597 any demonstrated improvement to reduce health status adjusted total medical expenses;

4598 (2) any ongoing strategies or investments that the health care entity is  
4599 implementing to improve future long-term efficiency and reduce cost growth, including  
4600 certification as a Beacon ACO;

4601 (3) whether the factors that led to increased costs for the health care entity can  
4602 reasonably be considered to be outside of the control of the entity and unanticipated;

4603 (4) the overall financial condition of the health care entity;

4604 (5) the proportionate impact of the health care entity's costs on the growth of total  
4605 health care medical expenses statewide;

4606 (6) a significant deviation between the projected economic growth benchmark and  
4607 the actual economic growth benchmark, as established under section 7H½ of chapter 29; and

4608 (7) any other factors the authority considers relevant, including any information or  
4609 testimony collected by the authority under the subsection (e) of section 6.

4610 If the authority declines to waive or extend the requirement for the health care entity to  
4611 file a performance improvement plan, the authority shall provide confidential notice to the health  
4612 care entity that its application for a waiver or extension was denied and the health care entity  
4613 shall file a performance improvement plan within 45 days.

4614 (e) A health care entity shall file a performance improvement plan: (i) within 45 days of  
4615 receipt of a notice under subsection (c); (ii) if the health care entity has requested a waiver or  
4616 extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or  
4617 (iii) if the health care entity is granted an extension, on the date given on such extension. The  
4618 performance improvement plan shall be generated by the health care entity and shall identify the  
4619 causes of the entity's cost growth and shall include, but not be limited to, specific strategies,  
4620 adjustments and action steps the entity proposes to implement to improve cost performance, as  
4621 measured by health status adjusted total medical expenses. The proposed performance  
4622 improvement plan shall include specific identified and measurable expected outcomes and a  
4623 timetable for implementation. The timetable for a performance improvement plan shall not  
4624 exceed 18 months.

4625 (f) The authority shall approve any performance improvement plan that it determines is  
4626 reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable  
4627 expectation for successful implementation.

4628 (g) If the board determines that the performance improvement plan is unacceptable or  
4629 incomplete, the authority may provide consultation on the criteria that have not been met and

4630 may allow an additional time period, up to 30 calendar days, for resubmission; provided  
4631 however, that all aspects of the performance improvement plan shall be proposed by the health  
4632 care entity and the authority shall not require specific elements for approval.

4633 (h) Upon approval of the proposed performance improvement plan, the authority shall  
4634 notify the health care entity to begin immediate implementation of the performance improvement  
4635 plan. Public notice shall be provided by the authority on its website identifying that the health  
4636 care entity is implementing a performance improvement plan; provided however, that the  
4637 performance improvement plan itself shall remain confidential. All health care entities  
4638 implementing an approved performance improvement plan shall be subject to additional  
4639 confidential reporting requirements and compliance monitoring, as determined by the authority.  
4640 The authority shall provide assistance to the health care entity in the successful implementation  
4641 of the performance improvement plan.

4642 (i) All health care entities shall, in good faith, work to implement the performance  
4643 improvement plan. At any point during the implementation of the performance improvement  
4644 plan the health care entity may file amendments to the performance improvement plan, subject to  
4645 approval of the authority.

4646 (j) At the conclusion of the timetable established in the performance improvement plan,  
4647 the health care entity shall report to the authority regarding the outcome of the performance  
4648 improvement plan. If the performance improvement plan was found to be unsuccessful, the  
4649 authority shall either: (i) extend the implementation timetable of the existing performance  
4650 improvement plan; (ii) approve amendments to the performance improvement plan as proposed  
4651 by the health care entity; (iii) require the health care entity to submit a new performance

4652 improvement plan under subsection (e); or (iv) waive or delay the requirement to file any

4653 additional performance improvement plans.

4654 (k) Upon the successful completion of the performance improvement plan, or a decision

4655 by the board to waive or delay the requirement to file a new performance improvement plan, the

4656 identity of the health care entity shall be removed from the authority's website.

4657 (l) If the authority determines that a health care entity has: (i) willfully neglected to file a

4658 performance improvement plan with the authority within 45 days as required under subsection

4659 (e); (ii) failed to file an acceptable performance improvement plan in good faith with the

4660 authority; (iii) failed to implement the performance improvement plan in good faith; or (iv)

4661 knowingly failed to provide information required by this section to the authority or that

4662 knowingly falsifies the same, the authority may assess a civil penalty to the health care entity of

4663 not more than \$500,000. The authority shall seek to promote compliance with this section and

4664 shall only impose a civil penalty as a last resort.

4665 (m) The authority may submit a recommendation of proposed legislation to the joint

4666 committee on health care financing if the authority believes that further legislative authority is

4667 needed to assist health care entities to implement successful performance improvement plans or

4668 to ensure compliance under this section.

4669 (n) The authority shall promulgate regulations as necessary to implement this section;

4670 provided however, that notice of any proposed regulations shall be filed with the joint committee

4671 on state administration and the joint committee on health care financing at least 180 days before

4672 adoption.

4673                   Section 8. (a) The authority, in consultation with the advisory board, shall develop  
4674 standards and a common application form for certain provider organizations to be voluntarily  
4675 certified as Beacon ACOs. The purpose of the Beacon ACO certification process shall be to  
4676 encourage the adoption of certain best practices by provider organizations in the commonwealth  
4677 related to cost containment, quality improvement and patient protection. Provider organizations  
4678 seeking this certification shall apply directly to the authority and shall submit all necessary  
4679 documentation as required by the authority. The Beacon ACO certification shall be assigned to  
4680 all provider organizations that meet the standards developed by the board.

4681                   (b) In developing standards for Beacon ACO certification, the authority shall review the  
4682 best practices employed by health care entities in the commonwealth and the standards included  
4683 in models developed by the Centers for Medicare & Medicaid Services, including the Pioneer  
4684 ACO, the Medicare Shared Savings Model and any safety net accountable care organization  
4685 models, and shall include, at a minimum, a requirement that all Beacon ACOs shall: (i) commit  
4686 to entering alternative payment methodology contracts with other purchasers; (ii) be a legal  
4687 entity with its own tax identification number, recognized and authorized under the laws of the  
4688 commonwealth; (iii) include patient and consumer representation on its governance; and (iv)  
4689 commit to ensuring at least 50 per cent of the Beacon ACO's primary care providers are  
4690 meaningfully using certified EHR technology as defined in the HITECH Act and subsequent  
4691 Medicare regulations.

4692                   (c) The board shall develop additional standards necessary to be certified as a Beacon  
4693 ACO, related to quality improvement, cost containment and patient protections. In developing  
4694 additional standards, the board shall consider, at a minimum, the following requirements for  
4695 Beacon ACOs:

4696 (1) to reduce the growth of health status adjusted total medical expenses over

4697 time, consistent with the state's efforts to meet the health care cost growth benchmark

4698 established under section 5;

4699 (2) to improve the quality of health services provided, as measured by the

4700 statewide quality measure set and other appropriate measures;

4701 (3) to ensure patient access to health care services across the care continuum,

4702 including, but not limited to, access to: preventive and primary care services; emergency

4703 services; hospitalization services; ambulatory patient services; mental health, substance use

4704 disorder and behavioral health services; access to specialty care units, including, but are not

4705 limited to, burn, coronary care, cancer care, including the services of a comprehensive cancer

4706 center, as defined in section 8 of chapter 118E, neonatal care, post-obstetric and post operative

4707 recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care

4708 units; pediatric services; obstetrics and gynecology services; diagnostic imaging and screening

4709 services; clinical laboratory and pathology services; maternity and newborn care services and

4710 related mental health outcomes; radiation therapy and treatment services; skilled nursing

4711 facilities; family planning services; home health services; treatment and prevention services for

4712 alcohol and other drug abuse; breakthrough technologies and treatments; allied health services

4713 including, but not limited to, advance practice nurses, optometric care, direct access to

4714 chiropractic services and physical therapy, occupational therapists, dental care, midwifery

4715 services, and end-of-life care services, including hospice and palliative care; and establishing

4716 mechanisms to protect patient provider choice, including parameters for out of Beacon

4717 ACOarrangements;

4718 (4) to accept and promote alternative payment methodologies consistent with the  
4719 standards developed by the authority under section 9 and the adoption of payment incentives  
4720 that improve quality and care coordination, including, but not limited to, incentives to reduce  
4721 avoidable hospitalizations, avoidable readmissions, adverse events and unnecessary emergency  
4722 room visits; incentives to reduce racial, ethnic and linguistic health disparities in the patient  
4723 population; and in all cases ensuring that alternative payment methodologies do not create any  
4724 incentive to deny or limit medically necessary care, especially for patients with high risk factors  
4725 or multiple health conditions;

4726 (5) to improve access to certain primary care services, including but not limited to, by  
4727 having a demonstrated primary care and care coordination capacity and a minimum number of  
4728 practices engaged in becoming patient centered medical homes;

4729 (6) to improve access to health care services and quality of care for vulnerable  
4730 populations including, but not limited to, children, the elderly, low-income individuals,  
4731 individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities,  
4732 including demonstrating an ability to provide culturally and linguistically appropriate care,  
4733 patient education and outreach provided by community health workers.

4734 (7) to promote the integration of mental health, substance use disorder and  
4735 behavioral, substance use disorder and mental health services with primary care services  
4736 including, but not limited to, the establishment of a behavioral health medical home, recovery  
4737 coaching and peer support and services provided by peer support workers, certified peer  
4738 specialists and licensed alcohol and drug counselors;

4739 (8) to promote patient-centeredness by, including, but not limited to, establishing  
4740 mechanisms to conduct patient outreach and education on the necessity and benefits of care  
4741 coordination, including group visits and chronic disease self-management programs;  
4742 demonstrating an ability to engage patients in shared decision making taking into account patient  
4743 preferences; demonstrating an ability to effectively involve patients in care transitions to improve  
4744 the continuity and quality of care across settings, with case manager follow up; demonstrating an  
4745 ability to engage and activate patients at home, through methods such as home visits or  
4746 telemedicine, to improve self-management; establishing mechanisms to evaluate patient  
4747 satisfaction with the access and quality of their care; establishing mechanismss between payers  
4748 and the provider organization such that any shared savings between the provider and the payer  
4749 shall contain a mechanism to return a percentage of the savings to the Beacon ACO participants;  
4750 and establishing mechanisms to protect patient provider choice, including parameters for  
4751 accessing care outside of the provider organization;

4752 (9) to adopt certain health information technology,data analysis functions and  
4753 performance management programs, including, but not limited to, population-based management  
4754 tools and functions; data stratification by sex and sex-race groups; the ability to aggregate and  
4755 analyze clinical data; the ability to electronically exchange patient summary records across  
4756 providers who are members of the Beacon ACO and other providers in the community to ensure  
4757 continuity of care; the ability to provide access to multi-payer claims data and performance  
4758 reports and the ability to share performance feedback on a timely basis with participating  
4759 providers; the ability to enable the beneficiary access to electronic health information; and the  
4760 utilization of a proven performance management program, including, but not limited to,  
4761 participation in the 2011-2012 Health Care Criteria for Performance Excellence as developed in

4762 conjunction with the Baldrige Criteria for Performance Excellence administered by the National  
4763 Institutes of Standards and Technology of the United States Department of Commerce;

4764 (10) to demonstrate excellence in the area of quality improvement and care  
4765 coordination, as evidenced by the success of previous or existing care coordination, pay for  
4766 performance, patient centered medical home, quality improvement or health outcomes  
4767 improvement initiatives, including, but not limited to, a demonstrated commitment to reducing  
4768 avoidable hospitalizations, adverse events and unnecessary emergency room visits;

4769 (11) to adopt protocols to promote provider integration, both with providers  
4770 within and outside of the provider organization, including, but not limited to, clinical integration  
4771 of the medical director of the laboratory, accredited or certified under the federal Clinical  
4772 Laboratory Improvements Act of 1988, providing these services to the organization;

4773 (12) to promote community-based wellness programs and community health  
4774 workers, consistent with efforts funded by the department of public health through the  
4775 Prevention and Wellness Trust Fund established in section 2G of chapter 111 and to promote  
4776 other activities that integrate community public health interventions with an emphasis on the  
4777 social determinants of health and which have been proven to improve health;

4778 (13) to promote worker training programs and skills training opportunities for  
4779 employees of the provider organization, consistent with efforts funded by the secretary of labor  
4780 and workforce development through the Health Care Workforce Transformation Trust Fund;

4781 (14) to adopt certain governance structure standards, including standards related  
4782 to financial conflicts of interest and transparency;

4783 (15) to adopt certain financial capacity standards, including certification under  
4784 subsection (e) of section 10 of chapter 12C, to protect Beacon ACOs from assuming excess risk;  
4785 and

4786 (16) to demonstrate the administrative, clinical and financial capability to meet the primary and  
4787 secondary care needs of a defined population of patients, consisting of a minimum number of  
4788 covered lives, as established by the authority;

4789 (17) any other requirements the board considers necessary.

4790 (d) The authority shall update the standards for certification as a Beacon ACO at least  
4791 every 2 years, or at such other times as the authority determines necessary. In developing the  
4792 standards, the authority shall seek to allow for provider organizations of different compositions,  
4793 including, but not limited to, hospital and physician organizations, physician group entities and  
4794 independent physician organizations, to successfully apply for certification. The authority may  
4795 waive certain Beacon ACO financial capacity standards for provider organizations composed of  
4796 safety net providers, including community hospitals, high Medicaid disproportionate share  
4797 hospitals and their affiliated providers, if the authority determines that such standards represent  
4798 an insurmountable barrier to successful certification. The Authority shall not deny a Beacon  
4799 ACO certification based solely on the geographic location or size of the provider organization.

4800 (e) Provider organizations seeking to maintain certification shall renew their certification  
4801 as a Beacon ACO every 2 years. Failure to meet the requirements represented in the certification  
4802 may result in decertification, as determined by the board.

4803 Section 9. The authority, in consultation with the advisory board, shall develop best  
4804 practices and standards for alternative payment methodologies for use by the group insurance

4805 commission, the office of Medicaid and any other state funded insurance program. Any  
4806 alternative payment methodology shall: (1) support the state's efforts to meet the health care cost  
4807 benchmark established in section 5; (2) include incentives for high quality, coordinated care,  
4808 including wellness services, primary care services and behavioral health services; (3) include a  
4809 risk adjustment element based on health status; (4) to the extent possible, include a risk  
4810 adjustment element that takes into account functional status, socioeconomic status or cultural  
4811 factors; (5) preserve the use of intergovernmental transfer financing mechanisms by the  
4812 governmental acute public hospital consistent with the Medical Assistance Trust Fund provisions  
4813 in effect as of fiscal year 2012; and (6) recognize the unique circumstances of high Medicaid  
4814 disproportionate share hospitals and other safety net providers with concentrated care in  
4815 government programs. The authority shall also consider methodologies to account for the  
4816 following costs: (i) medical education; (ii) stand-by services and emergency services, including,  
4817 but not limited to, trauma units and burn units; ; (iii) services provided by disproportionate share  
4818 hospitals or other providers serving underserved populations, including but not limited to, groups  
4819 which suffer adverse health outcomes based on race, sex, ethnicity, disability, housing type,  
4820 income level, primary language or educational attainment; (iv) services provided to children; (v)  
4821 research; (vi) care coordination and community based services provided by allied health  
4822 professionals, including, but not limited to, community health workers, legal advocates, medical  
4823 interpreters, clinical prevention specialists, human services workers, social workers and licensed  
4824 alcohol and drug counselors; (vii) the greater integration of behavioral, substance use disorder  
4825 and mental health; (viii) the use and the continued advancement of new medical technologies,  
4826 treatments, diagnostics or pharmacology products that offer substantial clinical improvements  
4827 and represent a higher cost than the use of current therapies; (ix) culturally and linguistically

4828 appropriate services; (x) interpreter services; (xi) dedicated care management responsibilities and  
4829 administrative responsibilities in alternative payment methodologies; and (xii) costs associated  
4830 with the services of a comprehensive cancer center, as defined in section 8 of chapter 118E.

4831 Any best practices and standards developed under this section shall be shared with all  
4832 private health plans for their voluntary adoption.

4833 Section 10. (a) The authority, in consultation with the advisory board, shall administer the  
4834 Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of  
4835 2011. The fund shall be used for the following purposes: (1) to support the activities of the  
4836 authority; and (2) to foster innovation in payment and health care service delivery.

4837 (b) The authority shall establish a competitive process for health care entities to develop,  
4838 implement, or evaluate promising models in payment and health care service delivery.  
4839 Assistance from the authority may take the form of incentives, grants, technical assistance,  
4840 evaluation assistance or partnerships, as determined by the authority.

4841 (c) Prior to making a request for proposals under subsection (b), the authority shall solicit  
4842 ideas for payment changes and health care delivery service reforms directly from providers,  
4843 provider organizations, carriers, research institutions, health professionals, public institutions of  
4844 higher education, community-based organizations and private-public partnerships, or any  
4845 combination thereof. The authority shall review payment and service delivery models so  
4846 submitted and shall seek input from other relevant stakeholders in evaluating their potential.

4847 (d) The authority shall consider proposals that achieve the following goals: (i) to support  
4848 safety-net provider and disproportionate share hospital participation in new payment and health  
4849 care service delivery models; (ii) to support the successful implementation of performance

4850 improvement plans by health care entities under section 7; (iii) to support cooperative effort  
4851 between representatives of employees and management that are focused on controlling costs and  
4852 improving the quality of care through workforce engagement; (iv) to support the evaluation of  
4853 mobile health and connected health technologies to improve health outcomes among under-  
4854 served patients with chronic diseases; and (v) to develop the capacity to safely and effectively  
4855 treat chronic, common and complex diseases in rural and underserved areas and to monitor  
4856 outcomes of those treatments.

4857 (e) All approved activities funded through the Healthcare Payment Reform Fund shall support the  
4858 commonwealth's efforts to meet the health care cost growth benchmark established under section  
4859 5, and shall include measurable outcomes in both cost reduction and quality improvement.

4860 (f) To the maximum extent feasible, the authority shall seek to coordinate expenditures  
4861 from the Healthcare Payment Reform Fund with other public expenditures from the Prevention  
4862 and Wellness Trust Fund, the e-Health Institute Trust Fund, the Health Care Workforce  
4863 Transformation Trust Fund, the Distressed Community Hospital Fund, the executive office of  
4864 health and human services, any funding available through the Medicare program and the CMS  
4865 Innovation Center, established under the federal Patient Protection and Affordable Care Act and  
4866 any funding expended under the Delivery System Transformation Initiative Master Plan and  
4867 hospital-specific plans approved in the MassHealth section 1115 demonstration waiver.

4868 (g) Activities funded through the Healthcare Payment Reform Fund which demonstrates  
4869 measurable success in improving care or reducing costs shall be shared with other providers,  
4870 provider organizations and payers as model programs which may be voluntarily adopted by such  
4871 other health care entities. The authority may also incorporate any successful models and

4872 practices into its standards for the Beacon ACO certification under section 8 and for alternative  
4873 payment methodologies established for state-funded programs under section 9.

4874 (h) The authority shall, annually on or before January 31, report on expenditures from the  
4875 Healthcare Payment Reform Fund. The report shall include, but not be limited to: (i) the revenue  
4876 credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs  
4877 of the authority; (iii) an itemized list of the funds expended through the competitive process and  
4878 a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of  
4879 the activities funded through grants. The report shall be provided to the chairs of the house and  
4880 senate committees on ways and means and the joint committee on health care financing and shall  
4881 be posted on the authority's website.

4882 Section 11. (a) All expenses incurred in carrying out this chapter shall be payable solely  
4883 from funds provided under the authority of this chapter and no liability or obligations shall be  
4884 incurred by the authority under this chapter beyond the extent to which monies shall have been  
4885 provided under this chapter.

4886 (b) The authority shall be liable on all claims made as a result of the activities, whether  
4887 ministerial or discretionary, of any member, officer or employee of the authority acting as such,  
4888 except for willful dishonesty or intentional violation of the law, in the same manner and to the  
4889 same extent as a private person under like circumstances; provided, however, that the authority  
4890 shall not be liable to levy or execution on any real or personal property to satisfy judgment, for  
4891 interest prior to judgment, for punitive damages or for any amount in excess of \$100,000.

4892 (c) No person shall be liable to the commonwealth, to the authority or to any other person  
4893 as a result of the person's activities, whether ministerial or discretionary, as a member, officer or

4894 employee of the authority except for willful dishonesty or intentional violation of the law;  
4895 provided, however, that such person shall provide reasonable cooperation to the authority in the  
4896 defense of any claim. Failure of such person to provide reasonable cooperation shall cause such  
4897 person to be jointly liable with the authority, to the extent that such failure prejudiced the defense  
4898 of the action.

4899 (d) The authority may indemnify or reimburse any person, or a person's personal  
4900 representative, for losses or expenses, including legal fees and costs, arising from any claim,  
4901 action, proceeding, award, compromise, settlement or judgment resulting from such person's  
4902 activities, whether ministerial or discretionary, as a member, officer or employee of the  
4903 authority; provided, that the defense of settlement thereof shall have been made by counsel  
4904 approved by the authority. The authority may procure insurance for itself and for its members,  
4905 officers and employees against liabilities, losses and expenses which may be incurred by virtue  
4906 of this section or otherwise.

4907 (e) No civil action under this chapter shall be brought more than 3 years after the date  
4908 upon which the cause thereof accrued.

4909 (f) Upon dissolution, liquidation or other termination of the authority, all rights and  
4910 properties of the authority shall pass to and be vested in the commonwealth, subject to the rights  
4911 of lien holders and other creditors. In addition, any net earnings of the authority, beyond that  
4912 necessary for retirement of any indebtedness or to implement the public purpose or purposes or  
4913 program of the commonwealth, shall not inure to the benefit of any person other than the  
4914 commonwealth.

4915           Section 12. The authority shall keep an accurate account of all its activities and of all its  
4916  receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year  
4917  to its board, to the governor, to the general court and to the state auditor, such reports to be in a  
4918  form prescribed by the board, with the written approval of the auditor. The board or the auditor  
4919  may investigate the affairs of the authority, may severally examine the properties and records of  
4920  the authority and may prescribe methods of accounting and the rendering of periodical reports in  
4921  relation to projects undertaken by the authority. The authority shall be subject to biennial audit  
4922  by the state auditor.

4923           Section 13. The authority may adopt regulations to implement this chapter.

4924           CHAPTER 176T

4925           CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

4926           Section 1. As used in this chapter, the following words shall, unless the context clearly  
4927  requires otherwise, have the following meanings:

4928           “Carrier”, an insurer licensed or otherwise authorized to transact accident or health  
4929  insurance under chapter 175; a nonprofit hospital service corporation organized under chapter  
4930  176A; a nonprofit medical service corporation organized under chapter 176B; a health  
4931  maintenance organization organized under chapter 176G; an organization entering into a  
4932  preferred provider arrangement under chapter 176I; a contributory group general or blanket  
4933  insurance for persons in the service of the commonwealth under chapter 32A; a contributory  
4934  group general or blanket insurance for persons in the service of counties, cities, towns and  
4935  districts and their dependents under chapter 32B; the medical assistance program administered  
4936  by the office of Medicaid under chapter 118E and under Title XIX of the Social Security Act or

4937 any successor statute; and any other medical assistance program operated by a governmental unit  
4938 for persons categorically eligible for such program.

4939 "Commissioner", the commissioner of insurance.

4940 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a  
4941 carrier.

4942 "Nondiscriminatory basis", a carrier shall be providing coverage on a non-discriminatory  
4943 basis if its plan does not contain any annual or lifetime dollar or unit of service limitation  
4944 imposed on coverage for the care provided by a physician assistant which is less than any annual  
4945 or lifetime dollar or unit of service limitation imposed on coverage for the same services by other  
4946 participating providers.

4947 "Participating provider", a provider who, under terms and conditions of a contract with  
4948 the carrier or with its contractor or subcontractor, has agreed to provide health care services to an  
4949 insured with an expectation of receiving payment, other than coinsurance, co-payments or  
4950 deductibles, directly or indirectly, from the carrier.

4951 "Physician assistant", a person who is a graduate of an approved program for the training  
4952 of physician assistants who is supervised by a registered physician under sections 9C to 9H,  
4953 inclusive, of chapter 112, and who has passed the Physician Assistant National Certifying Exam  
4954 or its equivalent.

4955 "Primary care provider", a health care professional qualified to provide general medical  
4956 care for common health care problems who (i) supervises, coordinates, prescribes or otherwise

4957 provides or proposes health care services; (ii) initiates referrals for specialist care and  
4958 chiropractic care; and (iii) maintains continuity of care within the scope of practice.

4959           Section 2. The commissioner and the group insurance commission shall require that all  
4960 carriers recognize physician assistants as participating providers subject to section 3 and shall  
4961 include coverage on a nondiscriminatory basis to their insureds for care provided by physician  
4962 assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall  
4963 include benefits for primary care, intermediate care and inpatient care, including care provided in  
4964 a hospital, clinic, professional office, home care setting, long-term care setting, mental health or  
4965 substance abuse program, or any other setting when rendered by a physician assistant who is a  
4966 participating provider and is practicing within the scope of the physician assistant's professional  
4967 authority as defined by statute, rule and physician delegation to the extent that such policy or  
4968 contract currently provides benefits for identical services rendered by a provider of health care  
4969 licensed by the commonwealth.

4970           Section 3. A participating provider physician assistant practicing within the scope of the  
4971 physician assistant's license, including all regulations requiring collaboration with or supervision  
4972 by a physician under section 9E of chapter 112, shall be considered qualified within the carrier's  
4973 definition of primary care provider to an insured.

4974           Section 4. Notwithstanding any general or special law to the contrary, a carrier that  
4975 requires the designation of a primary care provider shall provide its insured with an opportunity  
4976 to select a participating provider physician assistant as a primary care provider.

4977           Section 5. Notwithstanding any general or special law to the contrary, a carrier shall  
4978 ensure that all participating provider physician assistants are included on any publicly accessible  
4979 list of participating providers for the carrier.

4980           Section 6. A complaint for noncompliance against a carrier shall be filed with and  
4981 investigated by the commissioner or the group insurance commission, whichever shall have  
4982 regulatory authority over the carrier. The commissioner and the group insurance commission  
4983 shall promulgate regulations to implement this chapter.

4984           SECTION 163. Clause (5) of subsection (d) of section 8A of chapter 180 of the General  
4985 Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 100  
4986 and 101, the words “division of health care finance and policy pursuant to chapter 118G” and  
4987 inserting in place thereof the following words:- institute of health care finance and policy under  
4988 chapter 12C.

4989           SECTION 164. Subsection (a) of section 9 of chapter 209C of the General Laws, as so  
4990 appearing, is hereby amended by striking out, in lines 36 and 37, the words “the division of  
4991 medical assistance or division of health care finance and policy” and inserting in place thereof  
4992 the following words:- the office of Medicaid or the executive office of health and human  
4993 services.

4994           SECTION 165. Section 60K of chapter 231 of the General Laws, as so appearing, is  
4995 hereby amended by striking out, in line 14, the figure “4” and inserting in place thereof the  
4996 following figure:- 2.

4997           SECTION 166. Said chapter 231 is hereby amended by inserting after section 60K, the  
4998 following section:-

4999           Section 60L. (a) Except as provided in this section, a person shall not commence an  
5000   action against a provider of health care as defined in the seventh paragraph of section 60B unless  
5001   the person has given the health care provider written notice under this section of not less than  
5002   182 days before the action is commenced.

5003 (b) The notice of intent to file a claim required under subsection (a) shall be mailed to the  
5004 last known professional business address or residential address of the health care provider who is  
5005 the subject of the claim.

5006 (c) The 182 day notice period in subsection (a) shall be shortened to 90 days if:

5007 (1) the claimant has previously filed the 182 day notice required against another  
5008 health care provider involved in the claim; or

5009 (2) the claimant has filed a complaint and commenced an action alleging medical  
5010 malpractice against 1 or more of the health care providers involved in the claim.

5011 (d) The 182 day notice of intent required in subsection (a) shall not be required if the  
5012 claimant did not identify and could not reasonably have identified a health care provider to  
5013 which notice shall be sent as a potential party to the action before filing the complaint;

5014 (e) The notice given to a health care provider under this section shall contain, but need  
5015 not be limited to, a statement including:

5016 (1) the factual basis for the claim;

5017 (2) the applicable standard of care alleged by the claimant;

5018 (3) the manner in which it is claimed that the applicable standard of care was  
5019 breached by the health care provider;

5020 (4) the alleged action that should have been taken to achieve compliance with the  
5021 alleged standard of care;

5022 (5) the manner in which it is alleged the breach of the standard of care was the  
5023 proximate cause of the injury claimed in the notice; and

5024 (6) the names of all health care providers that the claimant is notifying under this  
5025 section in relation to a claim.

5026 (f) Not later than 56 days after giving notice under this section, the claimant shall allow  
5027 the health care provider receiving the notice access to all of the medical records related to the  
5028 claim that are in the claimant's control and shall furnish release for any medical records related  
5029 to the claim that are not in the claimant's control, but of which the claimant has knowledge.

5030 This subsection shall not restrict a patient's right of access to the patient's medical records under  
5031 any other law.

5032 (g) Within 150 days after receipt of notice under this section, the health care provider or  
5033 authorized representative against whom the claim is made shall furnish to the claimant or the  
5034 claimant's authorized representative a written response that contains a statement including the  
5035 following:

5036 (1) the factual basis for the defense, if any, to the claim;

5037 (2) the standard of care that the health care provider claims to be applicable to the  
5038 action;

5039 (3) the manner in which it is claimed by the health care provider that there was or

5040 was not compliance with the applicable standard of care; and

5041 (4) the manner in which the health care provider contends that the alleged

5042 negligence of the health care provider was or was not a proximate cause of the claimant's alleged

5043 injury or alleged damage.

5044 (h) If the claimant does not receive the written response required under subsection (g)

5045 within the required 150 day time period, the claimant may commence an action alleging medical

5046 malpractice upon the expiration of the 150 day time period. If a provider fails to respond within

5047 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other

5048 means then interest on any judgment against that provider shall accrue and be calculated from

5049 the date that the notice was filed rather than the date that the suit is filed. At any time before the

5050 expiration of the 150 day period, the claimant and the provider may agree to an extension of the

5051 150 day period.

5052 (i) If at any time during the applicable notice period under this section a health care

5053 provider receiving notice under this section informs the claimant in writing that the health care

5054 provider does not intend to settle the claim within the applicable notice period, the claimant may

5055 commence an action alleging medical malpractice against the health care provider, so long as the

5056 claim is not barred by the statute of limitations or repose.

5057 (j) A lawsuit against a health care provider filed within 6 months of the statute of

5058 limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any

5059 claimant, shall be exempt from compliance with this section.

5060 (k) Nothing in this section shall prohibit the filing of suit at any time in order to seek  
5061 court orders to preserve and permit inspection of tangible evidence.

5062 SECTION 167. Section 85K of said chapter 231, as appearing in the 2010 Official  
5063 Edition, is hereby amended by inserting, in line 8, after the word “costs”, the following words:-

5064 ; provided, however, in the context of medical malpractice claims against a non-profit  
5065 charity providing health care, such cause of action shall not exceed the sum of \$100,000,  
5066 exclusive of interest and costs.

5067 SECTION 168. Chapter 233 of the General Laws is hereby amended by inserting after  
5068 section 79K, the following new section:-

5069 Section 79L. (a) As used in this section, the following words shall, unless the context  
5070 clearly requires otherwise, have the following meanings:

5071 “Facility”, a hospital, clinic, or nursing home licensed under chapter 111, a psychiatric  
5072 facility licensed under chapter 19 or a home health agency; provided, that “facility” shall also  
5073 include any corporation, professional corporation, partnership, limited liability company, limited  
5074 liability partnership, authority or other entity comprised of such facilities.

5075 “Health care provider”, any of the following health care professionals licensed under  
5076 chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, dental  
5077 hygienist, optometrist, nurse, nurse practitioner, physician assistant, chiropractor, psychologist,  
5078 independent clinical social worker, speech-language pathologist, audiologist, marriage and  
5079 family therapist or mental health counselor; provided, that “health care provider” shall also

5080 include any corporation, professional corporation, partnership, limited liability company, limited  
5081 liability partnership, authority, or other entity comprised of such health care providers.

5082           “Unanticipated outcome”, the outcome of a medical treatment or procedure, whether or  
5083 not resulting from an intentional act, that differs from an intended result of such medical  
5084 treatment or procedure.

5085           (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly  
5086 experiencing an unanticipated outcome of medical care, any and all statements, affirmations,  
5087 gestures, activities or conduct expressing benevolence, regret, apology, sympathy,  
5088 commiseration, condolence, compassion, mistake, error or a general sense of concern which are  
5089 made by a health care provider, facility or an employee or agent of a health care provider or  
5090 facility, to the patient, a relative of the patient or a representative of the patient and which relate  
5091 to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative  
5092 proceeding, unless the maker of the statement, or a defense expert witness, when questioned  
5093 under oath during the litigation about facts and opinions regarding any mistakes or errors that  
5094 occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in  
5095 which case the statements and opinions made about the mistake or error shall be admissible for  
5096 all purposes. In situations where a patient suffers an unanticipated outcome with significant  
5097 medical complication resulting from the provider's mistake, the health care provider, facility or  
5098 an employee or agent of a health care provider or facility shall fully inform the patient, and when  
5099 appropriate the patient's family, about said unanticipated outcome.

5100           SECTION 169. Clause (2) of subsection (b) of section 3 of chapter 258C of the General  
5101 Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out sub-clause

5102 (A) and inserting in place thereof the following sub-clause:- (A) Expenses incurred for hospital  
5103 services as the direct result of injury to the victim shall be compensable under this chapter;  
5104 provided, however, that when claiming compensation for hospital expenses, the claimant shall  
5105 demonstrate an out-of-pocket loss or a legal liability for payment of said expenses. No hospital  
5106 expenses shall be paid if the expense is reimbursable by Medicaid or if the services are covered  
5107 by chapter 118E. Every claim for compensation for hospital services shall include a certification  
5108 by the hospital that the services are not reimbursable by Medicaid and that the services are not  
5109 covered by chapter 118E. In no event shall the amounts awarded for hospital services exceed the  
5110 rates for services established by the executive office of health and human services or a  
5111 governmental unit designated by the executive office if rates have been established for such  
5112 services.

5113 SECTION 170. The second paragraph of section 4 of chapter 260 of the General Laws,  
5114 as so appearing, is hereby amended by adding the following sentence:-

5115 The statutes of limitation and repose in this paragraph shall be tolled for a period of 180  
5116 days when a notice of intent to file a claim, under subsection (a) of section 60L of chapter 231, is  
5117 sent to a provider of health care as defined in the seventh paragraph of section 60B of chapter  
5118 231.

5119 SECTION 170A. Section 271 of chapter 127 of the acts of 1999 is hereby amended by inserting  
5120 in the first paragraph after the words “the secretary of the executive office of elder affairs” the  
5121 following words:- , the executive director of the commonwealth health insurance connector  
5122 authority.

5123 SECTION 170B. The first paragraph of said section 271 of said chapter 127 is hereby  
5124 further amended by striking out the words “(i) participants in the Senior Pharmacy program, so-  
5125 called, pursuant to section 16B of chapter 118E of the General Laws” and inserting in place  
5126 thereof the following words:- (i) enrollees in Commonwealth Care under chapter 176Q of the  
5127 General Laws.

5128 SECTION 170C. The first paragraph of section 62 of chapter 177 of the acts of 2001 is  
5129 hereby amended by inserting after the words “the commissioner of the group insurance  
5130 commission” the following words: - ,the executive director of the commonwealth health  
5131 insurance connector authority.

5132 SECTION 170D. Section 16 of chapter 257 of the acts of 2008, as most recently amended by  
5133 section 27 of chapter 9 of the acts of 2011, is hereby amended by striking out the words “section  
5134 7 of chapter 118G” and inserting in place thereof the following words:- section 13D of chapter  
5135 118E.

5136 SECTION 170E. Section 17 of said chapter 257, as most recently amended by section 28 of said  
5137 chapter 9 of the acts of 2011, is hereby amended by striking out the words “section 7 of chapter  
5138 118G” and inserting in place thereof the following words:- section 13D of chapter 118E.

5139 SECTION 170F. Section 18 of said chapter 257, as most recently amended by section 29  
5140 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words “section 7 of  
5141 chapter 118G” and inserting in place thereof the following words:- “section 13D of chapter  
5142 118E.

5143 SECTION 171. Section 15 of chapter 305 of the acts of 2008 is hereby repealed.

5144 SECTION 172. Chapter 288 of the acts of 2010 is hereby amended by striking out

5145 section 66 and inserting in place thereof the following section:-

5146 SECTION 66. For small group base rate factors applied under section 3 of chapter 176J

5147 of the General Laws between October 1, 2010 and July 1, 2015, a carrier shall limit the effect of

5148 the application of any single or combination of rate adjustment factors identified in paragraphs

5149 (2) to (6), inclusive, of subsection (a) of said chapter 3 of said chapter 176J that are used in the

5150 calculation of an individual's or small group's premium so that the final annual premium charged

5151 to an individual or small group does not increase by more than an amount established annually

5152 by the commissioner by regulation.

5153 SECTION 173. Section 70 of said chapter 288 is hereby amended by striking out the

5154 figure "2012" and inserting in place thereof the following figure:- 2015.

5155 SECTION 173A. Section 48 of chapter 9 of the acts of 2011 is hereby amended by

5156 striking out the words "section 7 of chapter 118G" and inserting in place thereof the following

5157 words:- section 13D of chapter 118E.

5158 SECTION 173B. (a)There is hereby established and set upon the books of the commonwealth a

5159 separate fund to be known as the Distressed Community Hospital Trust Fund, which shall be

5160 administered by the institute of health care finance and policy established under chapter 12C of

5161 the General Laws. Expenditures from the Distressed Community Hospital Trust Fund shall be

5162 dedicated to efforts to improve and enhance the ability of qualified community hospitals to serve

5163 populations in need more effectively.

5164 (b)The Distressed Community Hospital Trust Fund shall consist of any funds that may be  
5165 appropriated or transferred for deposit into the trust fund and any funds provided from other  
5166 sources.

5167 (c)The institute shall develop a competitive grant process for awards to be distributed from said  
5168 fund to qualified community hospitals. The grant process shall consider, among other factors:  
5169 payer mix, uncompensated care, financial health, geographic need and population need. In  
5170 assessing financial health, the institute shall take into account days cash on hand, net working  
5171 capital and earnings before income tax, depreciation and amortization.

5172 (d)A qualified community hospital shall not include a hospital that is a teaching hospital, a  
5173 hospital that is receiving delivery system transformation initiative funds or a hospital whose  
5174 relative prices are above the statewide median relative price.

5175 (e)The competitive grant process shall include, at a minimum, a comprehensive uses of  
5176 funds proposal and a sustainability plan. As a condition of an award, the institute may require a  
5177 qualified community hospital to agree to take steps to increase its sustainability, including  
5178 reconfiguration of services, changes in staffing, wages or benefits, changes in governance or a  
5179 transfer of ownership.

5180 SECTION 174. Notwithstanding any general or special law to the contrary, the  
5181 commissioner of public health, in consultation with the board of registration in medicine, shall  
5182 promulgate regulations on or before April 1, 2013 to enforce section 226 of chapter 111 of the  
5183 General Laws.

5184 SECTION 175. Notwithstanding any general or special law to the contrary, the  
5185 department of public health, in consultation with the division of insurance, shall examine and

5186 study best practices and successful models of private sector wellness and health management  
5187 programs in order to create a model wellness guide for payers, employers and consumers. The  
5188 department shall also issue a report that identifies those elements of said programs that should be  
5189 promoted in support of the state's efforts to meet the health care cost growth benchmark  
5190 established under section 5 of chapter 176S.

5191           The model guide shall provide the following information: (i) the importance of healthy  
5192 lifestyles, disease prevention, care management and health promotion programs; (ii) financial  
5193 and other incentives for brokers, payers and consumers to encourage health and wellness  
5194 program offerings for consumers and to expand options for individuals who do not have access  
5195 to these programs through their workplace; (iii) benefit designs that tie financial consequences to  
5196 health care choices; (iv) use of technology to provide wellness information and services; and (v)  
5197 identifying qualitative and quantitative program measures to place real value on program results  
5198 and track program effectiveness.

5199           In developing the report and model guide, the secretary shall consult with health care  
5200 stakeholders, including but not limited to: employers, including representatives of employers  
5201 with more than 50 employees and representatives of employers with less than 50 employees;  
5202 providers and provider organizations; health carriers; and consumers. The report, along with any  
5203 recommendations, shall be submitted to the joint committee on health care financing, the house  
5204 and senate committees on ways and means and the secretary of health and human services by  
5205 January 1, 2013. The recommendations shall assist in the development of strategies and  
5206 programs supported by the Prevention and Wellness Trust Fund established under section 2G of  
5207 chapter 111 of the General Laws.

5208                   SECTION 176. Notwithstanding any general or special law or rule or regulation to the  
5209 contrary, the commissioner of insurance shall adopt regulations requiring any carrier, as defined  
5210 in section 1 of chapter 176O of the General Laws, and their contractors to comply with and  
5211 implement the federal Mental Health Parity and Addiction Equity Act of 2008, section 511 of  
5212 Public Law 110-343 and applicable state mental health parity laws including, section 22 of  
5213 chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter  
5214 176B and sections 4, 4B and 4M of chapter 176G of the General Laws. The commissioner of  
5215 insurance shall adopt such regulations not later than January 1, 2013. The regulations shall be  
5216 implemented as part of any provider contract and any carrier's health benefit plans delivered,  
5217 issued, entered into, renewed or amended on or after July 31, 2012.

5218                   Starting on July 1, 2013, the commissioner of insurance shall require all carriers and their  
5219 contractors, to submit an annual report to the division of insurance and to the attorney general,  
5220 which shall be a public record, certifying and outlining how their health benefit plans comply  
5221 with the federal Mental Health Parity and Addiction Equity Act, applicable state mental health  
5222 parity laws, including said section 22 of said chapter 32A, said section 47B of said chapter 175,  
5223 said section 8A of said chapter 176A, said section 4A of said chapter 176B and said sections 4,  
5224 4B and 4M of said chapter 176G and this section. The division of insurance may, at the request  
5225 of the attorney general or in its own discretion, hold a public hearing relative to a carrier's  
5226 annual report.

5227                   SECTION 177. Notwithstanding any general or special law or rule or regulation to the  
5228 contrary, the office of Medicaid shall adopt regulations requiring any Medicaid health plan and  
5229 managed care organization and their health plans and any behavioral health management firm  
5230 and third party administrator under contract with a Medicaid managed care organization to

5231 comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008,  
5232 section 511 of Public Law 110-343 and applicable state mental health parity laws, including  
5233 section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A  
5234 of chapter 176B and sections 4, 4B and 4M of chapter 176G of the General Laws. The office of  
5235 Medicaid shall adopt such regulations not later than January 1, 2013. The regulations shall be  
5236 implemented as part of any provider contracts and any carrier's health benefit plans delivered,  
5237 issued, entered into, renewed or amended on or July 31, 2012.

5238 Starting on July 1, 2013, the office of Medicaid shall submit an annual report to the house  
5239 and senate chairs of the joint committee on health care financing, the house and senate chairs of  
5240 the joint committee on mental health and substance abuse, the clerk of the senate, the clerk of the  
5241 house of representatives and the attorney general certifying and outlining how the health benefit  
5242 plans under the office of Medicaid, and any of their contractors, comply with the federal Mental  
5243 Health Parity and Addiction Equity Act, applicable state mental health parity laws, including  
5244 said section 22 of said chapter 32A, said section 47B of said chapter 175, said section 8A of said  
5245 chapter 176A, said section 4A of said chapter 176B and said sections 4, 4B and 4M of said  
5246 chapter 176G and this section. The office of Medicaid may hold a hearing relative to a health  
5247 benefit plan's compliance with this section.

5248 SECTION 178. Notwithstanding any general or special law to the contrary, the board of  
5249 registration of medicine, established under section 10 of chapter 13 of the General Laws, shall  
5250 promulgate regulations relative to the education and training of physicians in the early disclosure  
5251 of adverse events, including, but not limited to, continuing medical education requirements.  
5252 Nothing in this section shall affect the total hours of continuing medical education required by  
5253 the board, including the number of hours required relative to risk management.

5254                   SECTION 178A. Notwithstanding any general or special law to the contrary, the board of  
5255 registration in nursing, established under section 13 of chapter 13 of the General Laws, shall  
5256 promulgate regulations relative to the education and training of advanced practice nurses  
5257 authorized to practice under section 80B of chapter 112, in the early disclosure of adverse events  
5258 including, but not limited to, continuing education requirements. Nothing in this section shall  
5259 affect the total hours of continuing education required by the board.

5260                   SECTION 179. Notwithstanding any general or special law to the contrary, the  
5261 department of public health, in consultation with the Betsy Lehman center for patient safety and  
5262 medical error reduction, established under section 16E of chapter 6A of the General Laws, shall  
5263 create an independent task force to study and reduce the practice of defensive medicine and  
5264 medical overutilization in the commonwealth, including but not limited to the overuse of  
5265 imaging and screening technologies. At least 1 member of the task force shall be a health care  
5266 consumer representative. The task force shall issue a report on the financial and non-financial  
5267 impacts of defensive medicine and the impact of overutilization on patient safety. The task force  
5268 shall file a report of its study, including its recommendations and drafts of any legislation, if  
5269 necessary, by filing the same with the clerks of the senate and house of representatives who shall  
5270 forward a copy of the report to the joint committee on public health and the joint committee on  
5271 health care financing within 1 year of the effective date of this act.

5272                   SECTION 180. Notwithstanding any general or special law to the contrary, to the extent  
5273 that the office of Medicaid, the group insurance commission, the commonwealth health  
5274 insurance connector authority and any other state funded insurance program determine that  
5275 accountable care organizations offer opportunities for cost-effective and high quality care, such  
5276 state funded insurance programs shall prioritize provider organizations which have been certified

5277 by the board of the health care quality and finance authority as Beacon ACOs, under section 8 of  
5278 chapter 176S, for the delivery of publicly funded health services, provided that such Beacon  
5279 ACOs, to the extent possible, assure the continuity of patient care.

5280 SECTION 181. Any provider organization that entered a network contract prior to the  
5281 effective date of chapter 12C of the General Laws, which organization receives, or represents  
5282 providers who collectively receive, at least \$10,000,000 in annual net patient service revenue  
5283 from carriers or third-party administrators or which has entered full-risk contracts or which is  
5284 corporately affiliated with a carrier, shall register under section 10 of said chapter 12C not later  
5285 than December 1, 2012. Any other provider organization that entered a network contract prior to  
5286 the effective date of said chapter 12C and is required under said section 10 of said chapter 12C to  
5287 register shall register not later than December 1, 2013.

5288 Notwithstanding any other provision of said chapter 12C, and as a condition of licensure  
5289 under chapter 111 of the General Laws, any provider that is part of or represented by a provider  
5290 organization that entered a network contract and fails to register under said section 10 of said  
5291 chapter 12C shall continue to deliver care under such network contract for the duration of such  
5292 contract, or a period of 5 years, whichever is longer, at the contract terms and payment levels in  
5293 effect upon the date the provider organization fails to register under said section 10 of said  
5294 chapter 12C.

5295 SECTION 182. There shall be a special task force to examine behavioral, substance use  
5296 disorder and mental health treatment, service delivery, integration of behavioral health with  
5297 primary care and behavioral, substance use disorder and mental health reimbursement systems.  
5298 The task force shall consist of 13 members: 1 of whom shall be the commissioner of mental

5299 health, who shall serve as chair; 1 of whom shall be a representative of the Massachusetts  
5300 Hospital Association; 1 of whom shall be a representative of the Massachusetts Organization for  
5301 Addiction Recovery; 1 of whom shall be a representative of the Massachusetts Recovery Home  
5302 Collaborative; 1 of whom shall be a representative of the Massachusetts Association of  
5303 Behavioral Health Systems; 1 of whom shall be a representative of the Home Care Alliance of  
5304 Massachusetts; 1 of whom shall be a representative of the Children's Mental Health Campaign; 1  
5305 of whom shall be a representative of the Association for Behavioral Healthcare; 1 of whom shall  
5306 be a representative of the Massachusetts Chapter of the National Association of Social Workers;  
5307 and 4 of whom shall be appointed by the governor: 1 of whom shall be a provider with  
5308 experience serving difficult to reach populations; 1 of whom shall be a provider with experience  
5309 in serving dually diagnosed patients; 1 of whom shall be a registered nurse; and 1 of whom shall  
5310 be a school nurse. In its examination, the task force shall review: (a) the most effective and  
5311 appropriate approach to including behavioral, substance use and mental health disorder, and  
5312 services in the array of services provided by integrated provider organizations, including  
5313 transition planning for providers and maintaining continuity of care; (b) how current prevailing  
5314 reimbursement methods and covered behavioral, substance use and mental health benefits may  
5315 need to be modified to achieve more cost effective, integrated and high quality behavioral,  
5316 substance use and mental health outcomes, particularly with respect to the effects of  
5317 cardiovascular disease, diabetes and obesity on patients with serious mental illness; (c) the extent  
5318 to which and how payment for behavioral health services should be included under alternative  
5319 payment methodologies, including how mental health parity and patient choice of providers and  
5320 services could be achieved and the design and use of medical necessity criteria and protocols; (d)  
5321 how best to educate all providers to recognize behavioral, substance use and mental health

5322 conditions and make appropriate decisions regarding referral to behavioral health services; and  
5323 (e) the unique privacy factors required for the integration of behavioral, substance use and  
5324 mental health information into interoperable electronic health records. The task force shall  
5325 submit its report, findings and recommendations, along with any proposed legislation and  
5326 regulatory changes, to the health care quality and finance authority, the clerks of the senate and  
5327 house of representatives, the house and senate chairs of the joint committee on mental health and  
5328 substance abuse and the house and senate chairs of the joint committee on health care financing  
5329 not later than July 1, 2013."

5330 SECTION 183. Notwithstanding any general or special law to the contrary, the  
5331 department of public health shall submit a health resource plan to the governor and the general  
5332 court, as required by section 25A of chapter 111 of the General Laws, not later than January 1,  
5333 2014.

5334 SECTION 184. There shall be a special task force to study issues related to the accuracy of  
5335 medical diagnosis in the commonwealth called the Massachusetts diagnostic accuracy task force.  
5336 The task force shall investigate and report on: (i) the extent to which diagnoses in the  
5337 commonwealth are accurate and reliable, including the extent to which different diagnoses and  
5338 inaccurate diagnoses arise from the biological differences between the sexes; (ii) the underlying  
5339 systematic causes of inaccurate diagnoses; (iii) an estimation of the financial cost to the state,  
5340 insurers and employers of inaccurate diagnoses; (iv) the negative impact on patients caused by  
5341 inaccurate diagnoses; and (v) recommendations to reduce or eliminate the impact of inaccurate  
5342 diagnoses.

5343           The Massachusetts diagnostic accuracy task force shall be comprised of 9 members: 1 of  
5344    whom shall be the secretary of health and human services, who shall chair the task force; 1 of  
5345    whom shall be the commissioner of public health or a designee; 1 of whom shall be the chair of  
5346    the board of registration in medicine or a designee; 1 of whom shall be the chair of the board of  
5347    registration in nursing or a designee; and 5 members chosen by the governor, 1 of whom shall be  
5348    a provider with experience in the area of diagnostic accuracy, 1 of whom shall be a representative  
5349    of a Massachusetts health plan, 1 of whom shall be an employer with experience in  
5350    implementing programs to address diagnostic inaccuracy, 1 whom shall represent an  
5351    organization based in the commonwealth with experience creating and supporting the  
5352    implementation of programs on diagnostic accuracy and value-based benefit design, and 1 of  
5353    whom shall be a non-physician health care provider.

5354           SECTION 185. Notwithstanding any general or special law to the contrary, the institute  
5355    of health care finance and policy shall, in consultation with the executive office of health and  
5356    human services, the department of public health, the office of Medicaid and the division of  
5357    insurance, review existing public reporting and data collection requirements for health care  
5358    providers, provider organizations and payers. The institute shall identify reporting and data  
5359    collection requirements that are unnecessary, duplicative, which could be combined or which  
5360    should be transferred to the institute in its role as the primary public health care data repository  
5361    for the commonwealth.

5362           The institute shall file the results of its review, together with drafts of legislation, if any,  
5363    necessary to carry out its recommendations, by filing the same with the clerks of the house of  
5364    representatives and the senate who shall forward a copy of the study to the house and senate

5365 committees on ways and means and the joint committee on health care financing not later than  
5366 January 1, 2014.

5367 SECTION 186. Notwithstanding any general or special law to the contrary, beginning not  
5368 later than July 1, 2014, the group insurance commission, MassHealth and any other state funded  
5369 insurance program shall, to the maximum extent feasible, implement alternative payment  
5370 methodologies, as defined in section 1 of chapter 12C. The alternative payment methodologies  
5371 shall be developed in consultation with the health care quality and finance authority under  
5372 section 8 of chapter 176S and all affected publically funded health plans, including, but not  
5373 limited to, the Medicaid managed care organizations. Any alternative payment methodology  
5374 shall be consistent with the best practices and standards developed by the health care quality and  
5375 finance authority under subsection (a) of section 9 of said chapter 176S.

5376 SECTION 187. Notwithstanding any general or special law to the contrary, the health  
5377 care quality and finance authority shall contract with an independent outside organization to  
5378 conduct a comprehensive review of the impact of this act, and transformations in the health care  
5379 payment system and care delivery system in the commonwealth, on health care consumers, the  
5380 health care workforce and the general public.

5381 The review shall include, but not be limited to, an investigation of:  
5382 (1) The impact on health care costs, including the extent to which savings have  
5383 reduced out-of-pocket costs to individuals and families, health insurance premium costs and  
5384 health care costs borne by the commonwealth;

5385 (2) The impact on access to health care services and quality of care in different  
5386 regions and for different populations, particularly for children, the elderly, low-income  
5387 individuals, individuals with disabilities and other vulnerable populations;

5388 (3) The impact on access and quality of care for specific services, particularly  
5389 primary care, behavioral, substance use disorder and mental health services;

5390 (4) The impact on the health care workforce, including, but not limited to, health  
5391 care worker recruitment and retention, health care worker shortages, training and education  
5392 requirements and job satisfaction; and

5393 (5) The impact on public health, including, but not limited to, reducing the  
5394 prevalence of preventable health conditions, improving employee wellness and reducing racial  
5395 and ethnic disparities in health outcomes.

5396 The organization shall, to the extent possible, obtain and use data from the institute of  
5397 health care finance and policy to conduct its analysis; provided, however, that such data shall be  
5398 confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4  
5399 of the General Laws.

5400 The health care quality and finance authority shall report the results of such review and  
5401 its recommendations, if any, together with drafts of legislation necessary to carry out such  
5402 recommendations to the house and senate committees on ways and means, the joint committee  
5403 on public health and post the results on the health care quality and finance authority's website  
5404 not later than March 31, 2017.

5405                   SECTION 188. Notwithstanding any general or special law or rule or regulation to the  
5406 contrary, upon the adoption of national electronic prior authorization standards by the National  
5407 Council for Prescription Drug Programs, the e-Health Institute shall prepare a report that  
5408 identifies the appropriate administrative regulations of the commonwealth that will need to be  
5409 promulgated in order to make those standards effective within 12 months of adoption of said  
5410 standards by the National Council for Prescription Drug Programs, as well as any steps that  
5411 should be taken to integrate information available through the commonwealth's prescription  
5412 monitoring program. The institute shall, not later than 6 months after the adoption of such  
5413 standards by the National Council for Prescription Drug Programs, submit its report together  
5414 with any further recommendations and draft legislative language necessary to carry out its  
5415 recommendations to the joint committee on public health, the joint committee on health care  
5416 financing and the governor.

5417                   SECTION 188A. The secretary of elder affairs, the undersecretary of the department of  
5418 housing and community development and the commissioner of the department of public health  
5419 shall, in conjunction with other agencies of the commonwealth as necessary, develop a state-  
5420 wide plan for the development and maintenance of assisted living facilities, long-term care  
5421 facilities, home health agencies and rest homes. The state-wide plan shall include an assessment  
5422 of existing and projected need for such facilities across all income levels, available capacity of  
5423 existing facilities for tenants at all income levels and projected development of additional  
5424 capacity in the next 25 years. The state-wide plan shall also assess any and all means being  
5425 utilized for payment by individuals for residence in assisted living facilities and the projected  
5426 availability of such means in the future for individuals, at all income levels, from public and  
5427 private sources, including, but not limited to, Medicare, Medicaid and private insurers.

5428           The state-wide plan, based on said assessments, shall include strategies to meet the  
5429    needs identified in such assessments and to facilitate the availability of assisted living facilities  
5430    for individuals of all income levels throughout the commonwealth, including the development  
5431    and maintenance of capital infrastructure, program services and public and private sources of  
5432    financing assisted living residences for the citizens of the commonwealth. The state-wide plan,  
5433    together with any recommendations for legislation necessary to carry out the plan, shall be filed  
5434    with the clerks of the senate and the house of representatives not later than 2 years after the  
5435    effective date of this act.

5436           SECTION 188B. Notwithstanding any general or special law to the contrary, the office  
5437    of Medicaid shall not terminate the coverage of any commonwealth care recipient, if: the office  
5438    has requested documentation, including the eligibility review form; the recipient has provided  
5439    such documentation on or before the date the office stated, in writing, that such documentation  
5440    was to be submitted; and the office has acknowledged receipt of the documentation, until the  
5441    office determines the eligibility for benefits based on the submitted information. The director  
5442    shall promulgate regulations to ensure the proper implementation of this section.

5443           SECTION 188C. The commonwealth health insurance connector authority shall  
5444    investigate and study the financial implications of non-residents to contributing employers under  
5445    section 188 of chapter 149 of the General Laws. The study shall include an analysis of the  
5446    amount of non-resident employees enrolled in employer sponsored health insurance plans, those  
5447    non-resident employees not enrolled in employer sponsored plans and the extent to which non-  
5448    residents contribute to assessments upon employers pursuant to section 188 of chapter 149 of the  
5449    general laws. The study shall consider any current adverse impacts from non-residents  
5450    participating in employer-sponsored plans and include recommendations to prevent such adverse

5451 impacts. The authority shall submit a report to the clerks of the house of representatives and  
5452 senate, the joint committee on health care financing and the house and senate committee on ways  
5453 and means before June 30, 2013.

5454 SECTION 189. There shall be a special commission to review public payer  
5455 reimbursement rates and payment systems for health care services and the impact of such rates  
5456 and payment systems on health care providers and on health insurance premiums in the  
5457 commonwealth. The commission shall consist of 11 members: 1 of whom shall be the secretary  
5458 of health and human services or a designee, who shall serve as chair; 1 of whom shall be the  
5459 director of the office of Medicaid; 1 of whom shall be the executive director of the institute of  
5460 health care finance and policy; 1 of whom shall be appointed by the Massachusetts Hospital  
5461 Association; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom  
5462 shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed  
5463 by the Home Care Alliance of Massachusetts; 1 of whom shall be appointed by the  
5464 Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the  
5465 Massachusetts Association for Behavioral Healthcare; and 2 of whom shall be appointed by the  
5466 governor, 1 of whom shall be represent managed care organizations contracting with MassHealth  
5467 and 1 of whom shall be an expert in medical payment methodologies from a foundation or  
5468 academic institution.

5469 The commission shall examine whether public payer rates and rate methodologies  
5470 provide fair compensation for health care services and promote high-quality, safe, effective,  
5471 timely, efficient, culturally competent and patient-centered care. The commission's analysis  
5472 shall include, but not be limited to, an examination of MassHealth rates and rate methodologies;  
5473 current and projected federal financing, including Medicare rates; cost-shifting and the interplay

5474 between public payer reimbursement rates and health insurance premiums; and the degree to

5475 which public payer rates reflect the actual cost of care.

5476 To conduct its review and analysis, the commission may contract with an outside

5477 organization with expertise in the analysis of health care financing. The institute of health care

5478 finance and policy and the office of Medicaid shall provide the outside organization, to the extent

5479 possible, with any relevant data necessary for the evaluation; provided, however, that such data

5480 shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of

5481 chapter 4 of the General Laws.

5482 The commission shall file the results of its study, together with drafts of legislation, if

5483 any, necessary to carry out its recommendations, by filing the same with the clerks of the house

5484 of representatives and the senate who shall forward a copy of the study to the house and senate

5485 committees on ways and means and the joint committee on health care financing not later than

5486 April 1, 2013.

5487 SECTION 189A. There shall be a special commission to examine the economic, social and

5488 educational value of graduate medical education in the commonwealth and to recommend a fair

5489 and sustainable model for the future funding of graduate medical education in the

5490 commonwealth.

5491 The commission shall consist of 13 members: 1 of whom shall be the secretary of health and

5492 human services or a designee, who shall serve as chair; 1 of whom shall be the secretary of

5493 administration and finance or a designee; 1 of whom shall be the secretary of labor and

5494 workforce development or a designee; 1 of whom shall be the commissioner of public health or a

5495 designee; 1 of whom shall be a representative of the Massachusetts Hospital Association; 1 of

5496 whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a  
5497 representative of the Massachusetts League of Community Health Centers; 4 of whom shall  
5498 represent each of the commonwealth's 4 medical schools; 1 of whom shall be a representative of  
5499 the Conference of Boston Teaching Hospitals; and 1 of whom shall be a resident in training at a  
5500 Massachusetts hospital, appointed by the secretary of health and human services.

5501 The commission shall investigate and report on the following issues:

5502 (1) the role of residents and medical faculty in the provision of health care in the  
5503 commonwealth and throughout the United States;

5504 (2) the relationship of graduate medical education to the state's physician workforce and  
5505 emerging models of delivery of care;

5506 (3) the current availability and adequacy of all sources of revenue to support graduate  
5507 medical education and potential additional or alternate sources of funding for graduate medical  
5508 education. Such review shall include the availability of federal graduate medical education  
5509 funding to different types of institutes where training takes place; and

5510 (4) approaches taken by other states to fund graduate medical education through  
5511 Medicaid programs, including, but not limited to: (a) the establishment of medical education  
5512 trust funds, and (b) efforts to link payments to state policy goals, including:

5513 (i) increasing the number of high demand specialties or fellowships;

5514 (ii) enhancing retention of physicians practicing in the commonwealth;

5515 (iii) promoting practice in medically underserved areas of the state and reducing disparities in  
5516 health care;

5517 (iv) increasing the primary care workforce;

5518 (v) increasing the behavioral health care workforce; and

5519 (vi) increasing racial and ethnic diversity within the physician workforce.

5520           The commission shall file a report of its findings and recommendations, together with  
5521           drafts of legislation, if any, necessary to carry out its recommendations by filing the same with  
5522           the clerks of the house of representatives and the senate who shall forward a copy of the report to  
5523           the house and senate committees on ways and means and the joint committee on health care  
5524           financing not later than April 1, 2013.

5525           SECTION 190. There shall be a special commission to review variation in prices among  
5526           providers. The commission shall consist of 22 members: 1 of whom shall be the executive  
5527           director of the institute of health care finance and policy or a designee, who shall serve as chair;  
5528           1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be  
5529           the executive director of the group insurance commission or a designee; 1 of whom shall be the  
5530           secretary of health and human services or a designee; 1 of whom shall be the attorney general or  
5531           a designee; 8 of whom shall be appointed by the governor, 1 of whom shall be a health  
5532           economist, 1 of whom shall have expertise in the area of health care payment methodology, 1 of  
5533           whom shall represent non-physician health care providers, 1 of whom shall represent an  
5534           academic medical center or teaching hospital, 1 of whom shall represent a high Medicaid and  
5535           low-income public payer disproportionate share hospital, 1 of whom shall represent a hospital  
5536           with 200 beds or less, 1 of whom shall be a nurse practitioner; 1 of whom shall represent  
5537           frontline nurses, and 1 of whom shall represent pharmaceutical manufacturers; 1 of whom shall  
5538           be appointed by the senate president and shall be a health economist or have expertise in the area

5539 of health care payment methodology; 1 of whom shall be appointed by the speaker of the house  
5540 of representatives and shall be a health economist or have expertise in the area of health care  
5541 payment methodology; 1 of whom shall be a representative of the Massachusetts Association of  
5542 Health Plans, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of  
5543 Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Hospital  
5544 Association, Inc.; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of  
5545 whom shall be a representative of the Massachusetts Medical Device Industry Council; and 1 of  
5546 whom shall be a representative of the Conference of Boston Teaching Hospitals.

5547           The commission shall conduct a rigorous analysis to identify the acceptable and  
5548 unacceptable factors contributing to price variation in physician, hospitals, diagnostic testing and  
5549 ancillary services. The analysis shall include, but not be limited to, an examination of the  
5550 following factors: quality, medical education, stand-by service capacity, emergency service  
5551 capacity, special services provided by disproportionate share hospitals and other providers  
5552 serving underserved or unique populations, market share of individual providers and affiliated  
5553 providers, provider size, advertising, location, research, costs, care coordination, community-  
5554 based services provided by allied health professionals and use of and continued advancement of  
5555 medical technology and pharmacology. The analysis shall also include a comparison of price  
5556 variation between providers in the commonwealth and providers in other states.

5557           After identifying such factors, the commission shall recommend steps to reduce provider  
5558 price variation and shall recommend the maximum reasonable adjustment to a commercial  
5559 insurer's median rate for individual or groupings of services for each acceptable factor.

5560 To conduct its review and analysis, the commission may contract with an outside  
5561 organization with expertise in the analysis of health care financing and provider payment  
5562 methodologies. The institute of health care finance and policy shall provide the commission and  
5563 any contracted outside organization, to the extent possible, relevant data necessary for the  
5564 evaluation; provided, however, that such data shall be confidential and shall not be a public  
5565 record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

5566 The commission shall file the results of its study, together with drafts of legislation, if  
5567 any, necessary to carry out its recommendations, by filing the same with the clerks of the house  
5568 of representatives and the senate who shall forward a copy of the study to the house and senate  
5569 committees on ways and means and the joint committee on health care financing not later than  
5570 January 1, 2014.

5571 SECTION 190A. There shall be a special commission to examine: (1) the feasibility of  
5572 implementing required co-pays for MassHealth services, the proceeds of which shall be  
5573 deposited into a trust fund to restore MassHealth adult dental benefits; and (2) methods to  
5574 encourage health care providers to accept patients covered by MassHealth on a limited basis. The  
5575 commission shall consist of 9 members: 1 of whom shall be the secretary of health and human  
5576 services or a designee, who shall serve as chair; 1 of whom shall be the director of the office of  
5577 Medicaid; 1 of whom shall be the executive director of the institute of health care finance and  
5578 policy; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom shall be  
5579 appointed by the Massachusetts Dental Society; 1 of whom shall be appointed by the  
5580 Massachusetts Senior Care Association; 1 of whom shall be appointed by the Massachusetts  
5581 League of Community Health Centers; 1 of whom shall be the executive director of Health Care

5582 For All, Inc.; and 2 of whom shall be appointed by the governor, 1 of whom shall represent  
5583 managed care organizations contracting with MassHealth.

5584 The commission shall file the results of its study, together with drafts of legislation, if  
5585 any, necessary to carry out its recommendations, by filing the same with the clerks of the house  
5586 of representatives and the senate who shall forward a copy of the study to the house and senate  
5587 committees on ways and means and the joint committee on health care financing not later than  
5588 October 1, 2013.

5589 SECTION 191. (a) There shall be an e-Health commission which shall evaluate the effectiveness  
5590 of expenditures authorized under section 6D of chapter 40J of the General Laws. The  
5591 commission shall consist of 17 members: 1 of whom shall be the secretary of administration and  
5592 finance or a designee, who shall serve as chair; 1 of whom shall be the secretary of health and  
5593 human services or a designee; 1 of whom shall be the executive director of the institute of health  
5594 care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic  
5595 development or a designee; 13 of whom shall be appointed by the governor, 1 of whom shall be  
5596 an expert in health information technology, 1 of whom shall be an expert in state and federal  
5597 health privacy laws, 1 of whom shall be an expert in health policy, 1 of whom shall be an expert  
5598 in health information technology relative to privacy and security, 1 of whom shall be from an  
5599 academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be  
5600 from a community health center, 1 of whom shall be from a long term care facility, 1 of whom  
5601 shall be from a physician group practice, 1 of whom shall be a front-line registered nurse, 1 of  
5602 whom shall be from a Medicare-certified home health agency, and 2 of whom shall represent  
5603 health insurance carriers.

5604 (b) The commission shall review the Massachusetts e-Health Institute, including an  
5605 analysis of all relevant data so as to determine the effectiveness and return on investment of  
5606 funding under said section 6D of said chapter 40J. The commission's review shall include  
5607 specific findings and legislative recommendations including the following:-

5608 (1) to what extent the program increased the adoption of interoperable electronic  
5609 health records, including to what extent the program increased the adoption of interoperable  
5610 electronic health records for providers;

5611 (2) to what extent the program reduced health care costs or the growth in health  
5612 care cost trends on a provider-based net cost and health plan based premium basis, including an  
5613 analysis of what entities benefitted from, or were disadvantaged by, any cost reductions and the  
5614 specific impact of the funding mechanism as established in subsection (a) of section 70 of  
5615 chapter 118E;

5616 (3) to what extent the program increased the number of health care providers in  
5617 achieving and maintaining compliance with the standards for meaningful use, beyond stage 1,  
5618 established by the United States Department of Health and Human Services;

5619 (4) to what extent the program should be discontinued, amended or expanded, and  
5620 if so, a timetable for implementation of the recommendations; and

5621 (5) to what extent additional public funding is needed for the e-Health Institute  
5622 Fund, as established in section 6E of chapter 40J of the General Laws.

5623 (c) To conduct these studies, the commission shall contract with an outside organization  
5624 with expertise in the analysis of the health care financing. In conducting its examination, the

5625 outside organization shall, to the extent possible, obtain and use actual health plan data from the  
5626 all-payer claims database as administered by the institute of health care finance and policy; but  
5627 such data shall be confidential and shall not be a public record for any purpose.

5628 (d) The commission shall report the results of its review and its recommendations, if any,  
5629 together with drafts of legislation necessary to carry out such recommendations by March 31,  
5630 2017. The report shall be provided to the chairs of the house and senate committees on ways and  
5631 means and the chairs of the joint committee on health care financing and shall be posted on the  
5632 department's website.

5633 SECTION 192. (a) There shall be a commission on prevention and wellness which shall  
5634 evaluate the effectiveness of the program authorized under section 2G of chapter 111 of the  
5635 General Laws. The commission shall consist of 20 members: 1 of whom shall be the  
5636 commissioner of public health or a designee, who shall serve as the chair; 1 of whom shall be the  
5637 executive director of the institute of health care finance and policy established in chapter 12C or  
5638 a designee; 1 of whom shall be the secretary of health and human services or a designee; 2 of  
5639 whom shall be the house and senate chairs of the joint committee on public health; 2 of whom  
5640 shall be the house and senate chairs of the joint committee on health care financing; and 12 of  
5641 whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field  
5642 of public health economics, 1 of whom shall be a person with expertise in public health research,  
5643 1 of whom shall be a person with expertise in the field of health equity, 1 of whom shall be a  
5644 person from a local board of health for a city or town with a population greater than 50,000, 1 of  
5645 whom shall be a person of a board of health for a city or town with a population less than 50,000,  
5646 2 of whom shall be representatives of health insurance carriers, 1 of whom shall be a person from  
5647 a consumer health organization, 1 of whom shall be a person from a hospital association, 1 of

5648 whom shall be a person from a statewide public health organization, 1 of whom shall be a  
5649 representative of the interest of businesses, 1 of whom shall be a person representing frontline  
5650 registered nurses and 1 of whom shall be a person from an association representing community  
5651 health workers.

5652 (b) The commission shall review the program authorized under said section 2G of said  
5653 chapter 111 and shall issue a report. The report shall include an analysis of all relevant data to  
5654 determine the effectiveness and return on investment of the program including, but not limited  
5655 to, an analysis of: (i) the extent to which the program impacted the prevalence of preventable  
5656 health conditions; (ii) the extent to which the program reduced health care costs or the growth in  
5657 health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the  
5658 reduction; (iv) the extent to which workplace-based wellness or health management programs  
5659 were expanded, and whether those programs improved employee health, productivity and  
5660 recidivism; (v) if employee health and productivity was improved or employee recidivism was  
5661 reduced, the estimated statewide financial benefit to employers; (vi) recommendations for  
5662 whether the program should be discontinued, amended or expanded, as well as a timetable for  
5663 implementation of the recommendations; and (vii) recommendations for whether the funding  
5664 mechanism for the Prevention and Wellness Trust Fund, as established under section 68 of  
5665 chapter 118E of the General Laws, should be extended beyond 2017, or whether an alternative  
5666 funding mechanism should be established

5667 (c) To conduct its evaluation, the commission shall contract with an outside organization  
5668 with expertise in the analysis of health care financing. In conducting its evaluation, the outside  
5669 organization shall, to the extent possible, obtain and use actual health plan data from the all-  
5670 payer claims database as administered by the institute of health care finance and policy;

5671 provided, however, that such data shall be confidential and shall not be a public record under  
5672 clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

5673 (d) The commission shall report the results of its investigation and study and its  
5674 recommendation, if any, together with drafts of legislation necessary to carry out such  
5675 recommendation to the house and senate committees on ways and means, the joint committee on  
5676 public health and shall be posted on the department's website not later than March 31, 2017.

5677 SECTION 192A. (a) There shall be a pharmaceutical cost containment commission established  
5678 to study methods to reduce the cost of prescription drugs for both public and private payers. The  
5679 commission shall consist of 16 members: 1 of whom shall be the senate chair of the joint  
5680 committee on health care financing; 1 of whom shall be the house chair of the joint committee on  
5681 health care financing; 1 of whom shall be the executive director of the group insurance  
5682 commission or a designee; 1 of whom shall be the director of the division of insurance or a  
5683 designee; 1 of whom shall be the director of the state office of pharmacy services or a designee;  
5684 1 of whom shall be the secretary of elder affairs or a designee; 1 of whom shall be the director of  
5685 the Massachusetts medicaid program or a designee; 3 of whom shall be appointed by senate, 1 of  
5686 whom shall be appointed by the minority leader; 3 of whom shall be appointed by the house of  
5687 representatives, 1 of whom shall be appointed by the minority leader; 1 of whom shall be a  
5688 representative of the Massachusetts Association of Health Plans; 1 of whom shall be a  
5689 representative of the Massachusetts Hospital Association; and 1 of whom shall be a  
5690 representative of Health Care For All. (b) The commission shall examine and report on the  
5691 following: (i) the ability of the commonwealth to enter into bulk purchasing agreements,  
5692 including agreements that would require the secretary of elder affairs, the executive director of  
5693 the group insurance commission, the director of the state office of pharmacy services, the

5694 commissioners of the departments of public health, mental health and mental retardation, and  
5695 any other state agencies involved in the purchase or distribution of prescription pharmaceuticals,  
5696 to renegotiate current contracts; (ii) aggregate purchasing methodologies designed to lower  
5697 prescription pharmaceutical costs for state and non-state providers; (iii) the ability of the  
5698 commonwealth to operate as a single payer prescription pharmaceutical provider; and (iv) the  
5699 feasibility of creating a program to provide all citizens access to prescription pharmaceuticals at  
5700 prices negotiated by the commonwealth.

5701 (c) The commission shall report the results of its findings, together with any  
5702 recommendations for legislation, programs and funding by filing the same with the clerks of the  
5703 house of representatives and the senate who shall forward copies of the report to the house and  
5704 senate committees on ways and means and the joint committee on health care financing not later  
5705 than 12 months after the effective date of this act.

5706 SECTION 193. (a) Notwithstanding any general or special law to the contrary, this  
5707 section shall facilitate the orderly transfer of employees, proceedings, rules and regulations,  
5708 property and legal obligations of the following functions of state government from the transferor  
5709 agency to the transferee agency, defined as follows:

5710 (1) the functions of the division of health care finance and policy, as the transferor  
5711 agency, to the institute of health care finance and policy, as the transferee agency; provided  
5712 however, that this section shall not apply to the functions of the division of health care finance  
5713 and policy that relate to the administration of the health safety net fund;

5714 (2) the functions of the division of health care finance and policy related to the  
5715 administration of the health safety net fund, as the transferor agency, to the office of Medicaid,  
5716 as the transferee agency;

5717 (3) the functions of the health care quality and cost council, as the transferor  
5718 agency, to the institute of health care finance and policy, as the transferee agency.

5719 (b) To the extent that employees of the transferor agency, including those who were  
5720 appointed immediately before the effective date of this act and who hold permanent appointment  
5721 in positions classified under chapter 31 of the General Laws or have tenure in their positions as  
5722 provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold  
5723 confidential positions, are transferred to the respective transferee agency, such transfers shall be  
5724 effected without interruption of service within the meaning of said section 9A of said chapter 31,  
5725 without impairment of seniority, retirement or other rights of the employee, and without  
5726 reduction in compensation or salary grade, notwithstanding any change in title or duties resulting  
5727 from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and  
5728 benefits, and without change in union representation or certified collective bargaining unit as  
5729 certified by the state division of labor relations or in local union representation or affiliation. Any  
5730 collective bargaining agreement in effect immediately before the transfer date shall continue in  
5731 effect and the terms and conditions of employment therein shall continue as if the employees had  
5732 not been so transferred. The reorganization shall not impair the civil service status of any such  
5733 reassigned employee who immediately before the effective date of this act either holds a  
5734 permanent appointment in a position classified under chapter 31 of the General Laws or has  
5735 tenure in a position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding  
5736 any other general or special law to the contrary, all such employees shall continue to retain their

5737 right to collectively bargain pursuant to chapter 150E of the General Laws and shall be  
5738 considered employees for the purposes of said chapter 150E. Nothing in this section shall be  
5739 construed to confer upon any employee any right not held immediately before the date of said  
5740 transfer, or to prohibit any reduction of salary grade, transfer, reassignment, suspension,  
5741 discharge, layoff, or abolition of position not prohibited before such date.

5742 (c) All petitions, requests, investigations and other proceedings appropriately and duly  
5743 brought before the transferor agency or duly begun by the transferor agency and pending before  
5744 it before the effective date of this act, shall continue unabated and remain in force, but shall be  
5745 assumed and completed by the transferee agency.

5746 (d) All orders, rules and regulations duly made and all approvals duly granted by the  
5747 transferor agency, which are in force immediately before the effective date of this act, shall  
5748 continue in force and shall thereafter be enforced, until superseded, revised, rescinded or  
5749 canceled, in accordance with law, by the transferee agency.

5750 (e) All books, papers, records, documents, equipment, buildings, facilities, cash and other  
5751 property, both personal and real, including all such property held in trust, which immediately  
5752 before the effective date of this act are in the custody of the transferor agency shall be transferred  
5753 to the transferee agency.

5754 (f) All duly existing contracts, leases and obligations of the transferor agency shall  
5755 continue in effect but shall be assumed by the transferee agency. No existing right or remedy of  
5756 any character shall be lost, impaired or affected by this act.

5757 SECTION 193A. Notwithstanding any general or special law to the contrary, the office  
5758 of Medicaid and the department of unemployment assistance shall, in consultation with the

5759 executive office of health and human services, develop and implement a means by which the  
5760 office of Medicaid may access information as to the status of or termination of unemployment  
5761 benefits and the associated insurance coverage by the medical security plan, as administered by  
5762 the executive office of labor and workforce development, for the purposes of determining  
5763 eligibility for those individuals applying for benefits through health care insurance programs  
5764 administered by the executive office of health and human services. The office and the  
5765 department shall implement this system not later than 3 months following the passage of this act;  
5766 provided, however, that if legislative action is required prior to implementation,  
5767 recommendations for such action shall be filed with the clerks of the house of representatives  
5768 and the senate and the joint committee on health care financing not later than 2 months following  
5769 the passage of this act.

5770 SECTION 194. Notwithstanding any general or special law to the contrary, the  
5771 commissioner of health care finance and policy as of the effective date of this act shall, with the  
5772 approval of the governor, become the interim executive director of the institute of health care  
5773 finance and policy on the effective date of this act. The interim executive director shall serve at  
5774 the pleasure of the governor, and may be removed by the governor at any time. If there is a  
5775 vacancy in the office of the interim executive director before January 1, 2014, the executive  
5776 director of the institute of health care finance and policy shall be appointed by a majority vote of  
5777 the governor, the auditor and the attorney general as required under section 2 of chapter 12C of  
5778 the General Laws.

5779 Beginning on January 1, 2014, the executive director of the institute of health care  
5780 finance and policy shall be appointed by a majority vote of the governor, the auditor and the  
5781 attorney general as required under section 2 of chapter 12C of the General Laws.

5782                   SECTION 195. Notwithstanding any general or special law or rule or regulation to the  
5783 contrary, all orders, rules and regulations duly made and all approvals duly granted by the  
5784 transferor agency, the division of health care finance and policy, in relation to sections 2A, 6B, 7,  
5785 9 to 15, 17, 25 and 28 to 39 of chapter 118G of the General Laws, which are in force  
5786 immediately before the effective date of this act, shall continue in force and shall thereafter be  
5787 enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the  
5788 transferee agency, the executive office of health and human services.

5789                   SECTION 196. Notwithstanding any general or special law or rule or regulation to the  
5790 contrary, all orders, rules and regulations duly made and all approvals duly granted by the  
5791 transferor agency, the division of health care finance and policy, in relation to section 18 of  
5792 chapter 15A, sections 6C and 18B of chapter 118G and section 188 of chapter 149 of the General  
5793 Laws, which are in force immediately before the effective date of this act, shall continue in force  
5794 and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance  
5795 with law, by the transferee agency, the commonwealth health insurance connector.

5796                   SECTION 197. Notwithstanding any general or special law or rule or regulation to the  
5797 contrary, all orders, rules and regulations duly made and all approvals duly granted by the  
5798 transferor agency, the division of health care finance and policy, in relation to sections 5, 6, 6A,  
5799 6½, 8, 16 and 23 of chapter 118G of the General Laws, which are in force immediately before  
5800 the effective date of this act, shall continue in force and shall thereafter be enforced, until  
5801 superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency, the  
5802 institute of health care finance and policy.

5803                   SECTION 198. Notwithstanding any general or special law or rule or regulation to the  
5804 contrary, all orders, rules and regulations duly made and all approvals duly granted by the  
5805 transferor agency, the division of health care finance and policy, in relation to section 41 chapter  
5806 118G of the General Laws, which are in force immediately before the effective date of this act,  
5807 shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or  
5808 canceled, in accordance with law, by the transferee agency, the department of public health.

5809                   SECTION 198A. The executive office of health and human services shall seek from the  
5810 secretary of the U.S. Department of Health and Human Services an exemption or waiver from  
5811 the Medicare requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing  
5812 facility be preceded by a 3-day hospital stay.

5813 SECTION 198B. The secretary of administration and finance and the secretary of health and  
5814 human services shall evaluate the feasibility of contracting for recycling durable medical  
5815 equipment purchased and issued by the commonwealth through any and all of its medical  
5816 assistance programs.

5817 Said evaluation shall include but not be limited to a request for qualifications or proposals for  
5818 entities capable of developing, implementing and operating a system of recycling whereby an  
5819 inventory of such equipment is developed and managed so as to maximize the quality of service  
5820 delivery to equipment recipients and to minimize costs and losses attributable to waste, fraud or  
5821 abuse.

5822                   The secretary of administration and finance shall report to the joint committee on health  
5823 care financing, the house committee on ways and means and the senate committee on ways and  
5824 means the findings of said evaluation, together with cost estimates for the operation of a

5825 recycling program, estimates of the savings it would generate and legislative recommendations,  
5826 not later than October 31, 2012.

5827 SECTION 198C. The institute of health care finance and policy shall conduct a  
5828 comprehensive study to investigate barriers to individuals seeking to change health insurance  
5829 plans, either upon a qualifying status change or during an open-enrollment period. The study  
5830 shall include, but not be limited to, the identification and review of such barriers, such as the  
5831 impact of a change in insurance plans on consumers who have used some or all of their yearly  
5832 plan deductibles, as well as recommendations for alleviating any barriers. The institute shall file  
5833 a report of its study, including recommendations and drafts of any legislation, if necessary, with  
5834 the clerks of the senate and house of representatives within 1 year of the effective date of this act.

5835 SECTION 198D. Subsection (c) of section 25A of chapter 111 of the General Laws and  
5836 clause (2) of subsection (g) of section 25C of said chapter 111 shall not apply to the review of  
5837 an application for a determination of need that is filed with the department of public health under  
5838 said chapter 111 until (i) October 1, 2013 or (ii) the date on which the department of public  
5839 health submits for the first time a health resource plan under said section 25A of said chapter  
5840 111, whichever occurs first.

5841 SECTION 198E. The office of Medicaid shall, within 6 months of the passage of this  
5842 act, take any and all necessary actions to ensure that social security numbers are required on all  
5843 medical benefits request forms to the extent permitted by federal law and that social security  
5844 numbers are provided by all applicants who possess them.

5845 If for any reason the office of Medicaid determines that it is or will be unable to  
5846 accomplish the foregoing within 6 months of the effective date of this act, the office shall submit

5847 a detailed report of the reasons for such inability to the clerks of the house of representatives and  
5848 the senate within 6 months following the effective date of this act.

5849 SECTION 198F. The institute of health care finance and policy shall, within 6 months of  
5850 the effective date of this act, ensure (i) that the identity, age, residence and eligibility of all  
5851 applicants are verified before payments, other than emergency bad debt payments, are made by  
5852 the Health Safety Net Trust Fund; and (ii) that the health safety net is the payor of last resort by  
5853 performing third party liability investigations on health safety net claims and by implementing  
5854 other such programs as needed.

5855 If for any reason the institute determines that it is or will be unable to accomplish the  
5856 foregoing within 6 months of the effective date of this act, the institute shall submit a detailed  
5857 report of the reasons for such inability to the clerks of the house of representatives and the senate  
5858 within 6 months of the effective date of this act.

5859 SECTION 199. The division of insurance shall develop prior authorization forms under  
5860 section 24 of chapter 176O of the General Laws not later than July 1, 2013.

5861 SECTION 199A. All appointments under section 192A shall be made within 60 days of  
5862 the effective date of this act.

5863 SECTION 199B. Section 271 of chapter 127 of the acts of 1999, as amended in sections  
5864 170A and 170B, and section 62 of chapter 177 of the acts of 2001, as amended in section 170C,  
5865 shall be fully implemented by January 1, 2013.

5866 SECTION 200. Section 87 shall take effect on January 1, 2015.

5867 SECTION 201. Section 70 of chapter 118E of the General Laws shall take effect on July  
5868 1, 2012.

5869 SECTION 202. Section 70 of chapter 118E of the General Laws is hereby repealed.

5870 SECTION 202A. The requirements of section 47BB of chapter 175 of the General Laws  
5871 shall apply to all policies, contracts and certificates executed, delivered, issued for delivery,  
5872 continued or renewed on or after January 1, 2013. For purposes of said section 47BB, all  
5873 contracts shall be considered to be renewed not later than the next yearly anniversary of the  
5874 contract date.

5875 SECTION 202B. Section 114A shall take effect on February 1, 2013.

5876 SECTION 203. Sections 144 and 147 shall take effect on July 1, 2013.

5877 SECTION 204. Sections 191 and 192 shall take effect on July 1, 2016.

5878 SECTION 205. Section 202 shall take effect on July 1, 2017.