

SENATE No. 02260

Senate, May 9, 2012 – New draft of House, No. 1849 reported from the Senate committee on the Ways and Means.

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17 hereby repealed.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.

46 (b) The attorney general shall, in consultation with the institute of health care finance and
47 policy, take appropriate action within existing statutory authority to prevent excess consolidation
48 or collusion of provider organizations and to remedy these or other related anti-competitive
49 dynamics in the health care market.

50 (c) The attorney general shall provide assistance as needed to support efforts by the
51 commonwealth to obtain exemptions or waivers from certain federal laws, to the extent the
52 attorney general determines such exemptions or waivers are necessary, including, from the

53 federal Office of the Inspector General, a waiver of, or expansion of, the “safe harbors” provided
54 for under 42 U.S.C. section 1320a-7b and obtaining from the federal Office of the Inspector
55 General a waiver of, or exemption from, 42 U.S.C. section 1395nn subsections (a) to (e).

56 (d) The attorney general may act under subsection (b) of section 15 of chapter 12C to
57 carry out this section.

58 SECTION 14. The General Laws are hereby further amended by inserting after chapter
59 12B the following chapter:-

60 Chapter 12C

61 Institute of Health Care Finance and Policy

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

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

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

71 “Alternative payment contract”, any contract between a provider or provider organization
72 and a public health care payer or a private health care payer which utilizes alternative payment
73 methodologies.

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

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

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

84 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health
85 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
86 176A; a nonprofit medical service corporation organized under chapter 176B; a health
87 maintenance organization organized under chapter 176G; and an organization entering into a
88 preferred provider arrangement under chapter 176I, but not including an employer purchasing
89 coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or
90 affiliated corporations of the employer; provided that, unless otherwise noted, the term “carrier”
91 shall not include any entity to the extent it offers a policy, certificate or contract that provides
92 coverage solely for dental care services or visions care services.

93 “Case mix”, the description and categorization of a hospital’s patient population
94 according to criteria approved by the institute including, but not limited to, primary and

95 secondary diagnoses, primary and secondary procedures, illness severity, patient age and source
96 of payment.

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

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

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

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

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

112 “Dispersed service area,” a geographic area of the commonwealth in which a provider
113 organization delivers health care services; provided, however, that the institute may by regulation
114 establish standards to determine dispersed service areas based on the number of zip codes, towns,

115 counties or primary service areas, which standards may vary based upon the population density
116 of various regions of the commonwealth.

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

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

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

124 “Executive director”, the executive director of the institute of health care finance and
125 policy.

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

130 "Fee-for-service", a form of contract under which a provider or provider organization is
131 paid for discrete and separate units of service and each provider is separately reimbursed for each
132 discrete service rendered to a patient; provided, however, that up to 10 per cent of total
133 reimbursement under such contracts may depend on the achievement of certain targets of
134 performance or conduct.

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

137 “General health supplies, care or rehabilitative services and accommodations”, all
138 supplies, care and services of medical, optometric, dental, surgical, podiatric, psychiatric,
139 therapeutic, diagnostic, rehabilitative, supportive or geriatric nature, including inpatient and
140 outpatient hospital care and services, and accommodations in hospitals, sanatoria, infirmaries,
141 convalescent and nursing homes, retirement homes, facilities established, licensed or approved
142 under chapter 111B and providing services of a medical or health-related nature, and similar
143 institutions including those providing treatment, training, instruction and care of children and
144 adults; provided, however, that rehabilitative service shall include only rehabilitative services of
145 a medical or health-related nature which are eligible for reimbursement under Title XIX of the
146 Social Security Act.

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

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

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

153 “Health care services”, supplies, care and services of medical, surgical, optometric,
154 dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative,
155 supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital
156 care and services; services provided by a community health center or by a sanatorium, as

157 included in the definition of “hospital” in Title XVIII of the federal Social Security Act, and
158 treatment and care compatible with such services or by a health maintenance organization.

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

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

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

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

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

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

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

179 “Major service category,” a set of service categories to be established by regulation,
180 which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii)
181 outpatient and ambulatory services, by categories as defined by the Centers for Medicare and
182 Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all
183 other” outpatient and ambulatory services that do not fall within a defined category; (iii)
184 behavioral and mental health services by categories as defined by the Centers for Medicare and
185 Medicaid, or as established by regulation; (iv) professional services, by categories as defined by
186 the Centers for Medicare and Medicaid, or as established by regulation; and (v) sub-acute
187 services, by major service line or clinical offering, as defined by regulation.

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

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

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

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

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

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

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

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

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

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

215 “Provider organization,” any corporation, partnership, business trust, association or
216 organized group of persons whether incorporated or not that consists of or represents 1 or more
217 providers in contracting with carriers for the payments the provider or providers receive for the
218 provision of health care services; provided, that “provider organization” shall include, but not be

219 limited to, physician organizations, physician-hospital organizations, independent practice
220 associations, provider networks, accountable care organizations and any other organization that
221 contracts with carriers for payment for health care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

271 "Total health care expenditures," the annual per capita sum of all health care expenditures
272 in the commonwealth, including public and private sources.

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

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

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

289 Section 3. There shall be an institute of health care finance and policy council. The
290 council shall advise on the overall operation and policy of the institute. The council shall be
291 chosen by the executive director and shall reflect a broad distribution of diverse perspectives on
292 the health care system, including health care professionals, educational institutions, consumer
293 representatives, providers, provider organizations and public and private payers

294 Section 4. The executive director may appoint and remove, subject to appropriation, such
295 agents and subordinate officers as the executive director may consider necessary and may
296 establish such subdivisions within the institute as the executive director considers appropriate to
297 fulfill the following duties: (i) to collect, analyze and disseminate health care data to assist in the
298 formulation of health care policy and in the provision and purchase of health care services
299 including, but not limited to, collecting, storing and maintaining data in a payer and provider
300 claims database; (ii) to provide an analysis of health care spending trends as compared to the
301 health care cost growth benchmark established by the health care quality and finance authority
302 under section 5 of chapter 176S; (iii) to develop and administer a registration system for provider
303 organizations and collect, analyze and disseminate information regarding provider organizations
304 to increase the transparency and improve the functioning of the health care system; (iv) to
305 provide information to, and work with, the general court and other state agencies including, but

306 not limited to, the executive office of health and human services, the department of public health,
307 the department of mental health, the health care quality and finance authority, the office of
308 Medicaid and the division of insurance to collect and disseminate data concerning the cost, price
309 and functioning of the health care system in the commonwealth and the health status of
310 individuals; (v) to participate in and provide data and data analysis for annual hearings conducted
311 by the health care quality and finance authority concerning health care provider and payer costs,
312 prices and cost trends; and (vi) report to consumers comparative health care cost and quality
313 information through the consumer health information website established under section 20. The
314 institute shall make available actual costs and prices of health care services, as supplied by each
315 provider, to the general public in a conspicuous manner on the institute's official website.

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

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

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

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

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

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

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

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

335 The assessed amount for hospitals shall be not less than 33 per cent of the amount
336 appropriated by the general court for the expenses of the institute minus amounts collected from
337 (1) filing fees; (2) fees and charges generated by the institute's publication or dissemination of
338 reports and information; and (3) federal matching revenues received for these expenses or
339 received retroactively for expenses of predecessor agencies. Each acute hospital shall pay such
340 assessed amount multiplied by the ratio of the hospital's gross patient service revenues to the
341 total of all such hospital's gross patient services revenues. Each acute hospital shall make a
342 preliminary payment to the institute on October 1 of each year in an amount equal to ½ of the
343 previous year's total assessment. Thereafter, each hospital shall pay, within 30 days notice from
344 the institute, the balance of the total assessment for the current year based upon its most current
345 projected gross patient service revenue. The institute shall subsequently adjust the assessment for
346 any variation in actual and estimated expenses of the institute and for changes in hospital gross
347 patient service revenue. Such estimated and actual expenses shall include an amount equal to the
348 cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D
349 of chapter 29. In the event of late payment by any such hospital, the treasurer shall advance the

350 amount of due and unpaid funds to the institute prior to the receipt of such monies in anticipation
351 of such revenues up to the amount authorized in the then current budget attributable to such
352 assessments and the institute shall reimburse the treasurer for such advances upon receipt of such
353 revenues. This section shall not apply to any state institution or to any acute hospital which is
354 operated by a city or town.

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

362 Section 9. (a) The institute shall promulgate regulations to require providers to report
363 such data as necessary to identify, on a patient-centered and provider-specific basis, statewide
364 and regional trends in the cost, price, availability and utilization of medical, surgical, diagnostic
365 and ancillary services provided by acute hospitals, nursing homes, chronic care and rehabilitation
366 hospitals, other specialty hospitals, clinics, including mental health clinics and such ambulatory
367 care providers as the institute may specify. Such regulations shall ensure uniform reporting of
368 revenues, charges, prices, costs and utilization of health care services delivered by institutional
369 and non-institutional providers and, relative to acute care hospitals, uniform reporting of hospital
370 inpatient and outpatient costs, including direct and indirect costs.

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

384 (c) The institute shall also collect and analyze such data as it considers necessary in order
385 to better protect the public's interest in monitoring the financial conditions of acute hospitals.
386 Such information shall be analyzed on an industry-wide and hospital-specific basis and shall
387 include, but not be limited to: (i) gross and net patient service revenues; (ii) sources of hospital
388 revenue, including revenue excluded from consideration in the establishment of hospital rates
389 and charges under section 13G of chapter 118E; (iii) private sector charges; (iv) trends in
390 inpatient and outpatient case mix, payer mix, hospital volume and length of stay; and (v) other
391 relevant measures of financial health or distress.

392 The institute shall publish annual reports and establish a continuing program of
393 investigation and study of financial trends in the acute hospital industry, including an analysis of

394 systemic instabilities or inefficiencies that contribute to financial distress in the acute hospital
395 industry. Such reports shall include an identification and examination of hospitals that the
396 institute considers to be in financial distress, including any hospitals at risk of closing or
397 discontinuing essential health services, as defined by the department of public health under
398 section 51G of chapter 111, as a result of financial distress.

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

402 (d) The institute shall publicly report and place on its website information on health status
403 adjusted total medical expenses including a breakdown of such health status adjusted total
404 medical expenses by major service category and by payment methodology, relative prices and
405 hospital inpatient and outpatient costs, including direct and indirect costs under this chapter on
406 an annual basis; provided, however, that at least 10 days prior to the public posting or reporting
407 of provider specific information the affected provider shall be provided the information for
408 review. The institute shall request from the federal Centers for Medicare and Medicaid Services
409 the health status adjusted total medical expenses of provider groups that serve Medicare patients.

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

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

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

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

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

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

424 (6) provider profiles and other information that have been compiled regarding
425 provider performance shall be shared with providers under review prior to dissemination;
426 provided, however, that opportunity for corrections and additions of helpful explanatory
427 comments shall be provided prior to publication; and, provided, further, that such profiles shall
428 only include data which reflect care under the control of the provider for whom such profile is
429 prepared;

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

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

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

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

439 Section 10. (a) The institute shall develop and administer a registration program for
440 provider organizations and shall collect and analyze such data as it considers necessary in order
441 to better protect the public's interest in monitoring the financial conditions, organizational
442 structure, market power and business practices of provider organizations. The institute shall
443 promulgate such regulations as may be necessary to ensure the uniform reporting of data
444 collected under this section. Such uniform reporting shall, at a minimum, enable the institute to
445 identify and analyze: (i) the organizational structure of each provider organization, including
446 parent entities, clinical affiliates and corporate affiliates as applicable; (ii) the financial condition
447 and solvency of each provider organization and ability to manage any alternative payment
448 contracts that it has entered into; and (iii) market share by provider organization by primary
449 service areas, dispersed service areas and the categories of services provided.

450 (b) The institute shall establish by regulation at least 5 levels of registration requirements
451 and standards for provider organizations which vary based on factors including degree of
452 provider integration, operational size, annual net patient service revenue, related business
453 activities including insurance and the extent to which the provider organization accepts
454 alternative payment methodologies. One level of registration requirements and standards shall be
455 applicable to provider organizations certified as Beacon ACOs by the health care quality and

456 finance authority. One level of standards and registration requirements shall be designed for
457 provider organizations that do not accept risk payments. For each level, the institute shall
458 establish minimum registration and public reporting requirements on consumer protections and
459 quality benchmarks.

460 (c)The institute shall require, at a minimum, that all provider organizations provide: (i)
461 organizational charts showing the ownership, governance and operational structure of the
462 provider organization, including any clinical affiliations and community advisory boards; (ii) the
463 number of affiliated health care professional full-time equivalents by license type, specialty,
464 name and address of principal practice location and whether the professional is employed by the
465 organization; (iii) the name and address of licensed facilities by license number, license type and
466 capacity in each major service category; (iv) a comprehensive financial statement, including
467 information on parent entities and corporate affiliates as applicable, and including details
468 regarding annual costs, annual receipts, realized capital gains and losses, accumulated surplus
469 and accumulated reserves; (v) Information on stop-loss insurance and any non-fee-for-service
470 payment arrangements; (vi) information on clinical quality, care coordination and patient referral
471 practices; (vii) information regarding expenditures and funding sources for payroll, teaching,
472 research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions; (viii)
473 information regarding charitable care and community benefit programs; (ix) for any provider
474 organization which enters alternative payment contracts, a certification under subsection (e); and
475 (x) such other information as the institute considers appropriate.

476 (d) Each registered provider organization shall annually file with the institute a
477 comprehensive financial statement showing the organization's financial condition for the prior
478 year, including information on parent entities and corporate affiliates as applicable and such

479 other information as the institute may require by regulation, such as organizational or clinical
480 information. Annual reporting shall be in a form provided by the institute and shall include, at a
481 minimum, sufficient information to demonstrate the solvency of the provider organization and
482 its ability to manage any alternative payment contracts into which it has entered. Any provider
483 organization which enters or renews alternative payment contracts shall provide, with the
484 provider organization's annual report, a certification under subsection (e). The institute may
485 require in writing, at any time, such additional information as is reasonable and necessary to
486 determine the financial condition of a registered provider organization.

487 (e) The institute shall, in collaboration with the division of insurance, establish by
488 regulation a certification process for any provider organization which enters into alternative
489 payment contracts. Such certification process shall be designed to determine whether a provider
490 organization has adequate reserves and other measures of financial solvency to meet its risk
491 arrangements. The standards for such certification may vary based on the provider organization
492 size, the type of alternative payment methodology employed, the amount and type of risk
493 assumed and such other criteria as the commissioner of insurance considers appropriate to ensure
494 that provider organizations do not assume excess risk. The institute, in collaboration with the
495 division of insurance, shall establish a schedule to renew such certification; provided, that such
496 certification be renewed at least annually.

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

502 (g) Every provider organization shall, before making any change to its operations or
503 governance structure affecting the provider organization's registration, submit notice to the
504 institute of such change. The institute may promulgate regulations prescribing the contents of
505 any notices required to be filed under this section. The institute may promulgate regulations
506 further defining material change and not material change.

507 If the change is not material, the notice shall be filed not fewer than 15 days before the
508 date of the change. A change that is not material may proceed on the date identified in the notice
509 once the notice has been accepted by the institute. Changes that are not material, for purposes of
510 this section, shall include, at a minimum, changes in board membership except when such
511 changes are related to a corporate affiliation, changes involving employment decisions by the
512 provider organization, changes that are subject to review by a state agency through any other
513 administrative process and changes that are necessary to comply with state or federal law. The
514 institute may promulgate regulations defining additional categories of changes that it shall
515 consider not material.

516 If the change is material, the notice shall be filed not fewer than 60 days before the date
517 of the change. Within 30 days of receipt of a notice filed under the institute's regulations, the
518 institute shall conduct a preliminary review to determine whether the change is likely to result in
519 a significant impact on the commonwealth's ability to meet the health care cost growth
520 benchmark, established in section 5 of chapter 176S, on the competitive market or on a provider
521 organization's solvency. Material changes that are likely to result in a significant impact shall
522 include, but not be limited to: a corporate affiliation between a provider organization and a
523 carrier; mergers or acquisitions of hospitals or hospital systems; acquisition of insolvent provider
524 organizations; and mergers or acquisitions of provider organizations which will result in a

525 provider organization having a near-majority of market share in a given service or region. The
526 institute shall specify, through regulations, other categories of material changes likely to result in
527 significant impact. The institute may require supplementary submissions from the provider
528 organization to provide data necessary to carry out this preliminary review. A provider
529 organization's supplementary submissions shall be confidential and shall not be considered a
530 public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 until the issuance
531 of the institute's report on its findings as a result of the preliminary review.

532 If the institute finds that the material change is unlikely to have a significant impact on
533 the commonwealth's ability to meet the health care cost growth benchmark, established in
534 section 5 of chapter 176S, on the competitive market or on the provider organization's solvency,
535 then the institute shall notify the provider organization of the outcome of its preliminary review
536 and the material change may proceed on the date identified in the notice. If the institute finds
537 that the material change is likely to have a significant impact on the commonwealth's ability to
538 meet the health care cost growth benchmark, on the competitive market or on the provider
539 organization's solvency, the institute shall conduct a cost, market impact and solvency review
540 under subsection (h).

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

546 The institute shall initiate a cost, market impact and solvency review by sending the
547 provider organization a notice of a cost, market impact and solvency review which shall explain
548 the particular factors that the institute seeks to examine through the review. The institute shall
549 notify the attorney general and the division of insurance whenever it initiates a cost, market
550 impact and solvency review and shall issue a public notice soliciting comments to inform its
551 review. The provider organization shall submit to the institute and the attorney general, within
552 21 days of the institute's notice, a written response to the notice, including, but not limited to,
553 any information or documents sought by the institute's notice. A provider organization's written
554 response shall be confidential and shall not be considered a public record under clause Twenty-
555 sixth of section 7 of chapter 4 or chapter 66 only until such time as the executive director
556 determines the response is complete.

557 A cost, market impact and solvency review may examine factors including, but not
558 limited to: (i) the provider organization's size and market share within its primary service areas
559 by major service category, and within its dispersed service areas; (ii) provider price, including its
560 relative prices filed with the institute; (iii) provider quality, including patient experience; (iv)
561 provider cost and cost trends in comparison to total health care expenditures statewide; (v) the
562 availability and accessibility of services similar to those provided, or proposed to be provided,
563 through the provider organization within its primary service areas and dispersed service areas;
564 (vi) the provider organization's impact on competing options for the delivery of health care
565 services within its primary service areas and dispersed service areas; (vii) the methods used by
566 the provider organization to attract patient volume and to recruit or acquire health care
567 professionals or facilities; (viii) the role of the provider organization in serving at-risk,
568 underserved and government payer patient populations within its primary service areas and

569 dispersed service areas; (ix) the role of the provider organization in providing low margin or
570 negative margin services within its primary service areas and dispersed service areas; (x) the
571 financial solvency of the provider organization; (xi) consumer concerns, including but not
572 limited to, complaints or other allegations that the provider organization has engaged in any
573 unfair method of competition or any unfair or deceptive act or practice; and (xii) any other
574 factors that the institute determines to be in the public interest.

575 The institute shall issue a final report on the cost, market impact and solvency review
576 within 60 days of receipt of a notice of material change filed under subsection (g) and which the
577 institute determined was likely to result in significant impact on the commonwealth's ability to
578 meet the health care cost growth benchmark, established in section 5 of chapter 176S, on the
579 competitive market or on the provider organization's solvency. The institute shall forward a copy
580 of the final report to the attorney general and the division of insurance.

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

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

591 among plans and plan types, including the self-insured. The institute shall adopt regulations to
592 require private and public health care payers to submit claims data, member data and provider
593 data to develop and maintain a database of health care claims data under this chapter.

594 (b) The institute shall require the submission of data and other information from each
595 private health care payer offering small or large group health plans including, but not limited to:
596 (i) average annual individual and family plan premiums for each payer's most popular plans for a
597 representative range of group sizes, as further determined in regulations and average annual
598 individual and family plan premiums for the lowest cost plan in each group size that meets the
599 minimum standards and guidelines established by the division of insurance under section 8H of
600 chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for
601 each plan; (iii) summaries of the plan and network designs for each plan, including whether
602 behavioral health or other specific services are carved-out from any plans; (iv) information
603 concerning the medical and administrative expenses, including medical loss ratios for each plan,
604 using a uniform methodology and collected under section 21 of chapter 176O; (v) information
605 concerning the payer's current level of reserves and surpluses; (vi) information on provider
606 payment methods and levels; (vii) health status adjusted total medical expenses by registered
607 provider organization, provider group and local practice group and zip code calculated according
608 to the method established under section 51 of chapter 288 of the acts of 2010; (viii) relative
609 prices paid to every hospital, registered provider organization, physician group, ambulatory
610 surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled
611 nursing facility and home health provider in the payer's network, by type of provider, with
612 hospital inpatient and outpatient prices listed separately and product type, including health
613 maintenance organization and preferred provider organization products and determined using

614 the method established under section 52 of chapter 288 of the acts of 2010; (ix) hospital inpatient
615 and outpatient costs, including direct and indirect costs, according to a uniform methodology; (x)
616 the annual rate of growth, stated as a percentage, of the weighted average relative price by
617 provider type and product type for the payer's participating health care providers, whether that
618 rate exceeds the rate of growth of the applicable producer price index as reported by the United
619 States Bureau of Labor Statistics and identified by the commissioner of insurance and whether
620 that rate exceeds the rate of growth in projected economic growth benchmark established under
621 section 7H½ of chapter 29; and (xi) a comparison of relative prices for the payer's participating
622 health care providers by provider type which shows the weighted average relative price, the
623 extent of variation in price, stated as a percentage and identifies providers who are paid more
624 than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20
625 per cent below the weighted average relative price.

626 (c) The institute shall require the submission of data and other information from public
627 health care payers including, but not limited to: (i) average premium rates for health insurance
628 plans offered by public payers and information concerning the actuarial assumptions that
629 underlie these premiums; (ii) average annual per-member per-month payments for enrollees in
630 MassHealth primary care clinician and fee for service programs; (iii) summaries of plan and
631 network designs for each plan or program, including whether behavioral health or other specific
632 services are carved-out from any plans; (iv) information concerning the medical and
633 administrative expenses, including medical loss ratios for each plan or program; (v) where
634 appropriate, information concerning the payer's current level of reserves and surpluses; (vi)
635 information on provider payment methods and levels, including information concerning payment
636 levels to each hospital for the 25 most common medical procedures provided to enrollees in

637 these programs, in a form that allows payment comparisons between Medicaid programs and
638 managed care organizations under contract to the office of Medicaid; (vii) health status adjusted
639 total medical expenses by registered provider organization, provider group and local practice
640 group and zip code calculated according to the method established under section 51 of chapter
641 288 of the acts of 2010;; and (viii) relative prices paid to every hospital, registered provider
642 organization, physician group, ambulatory surgical center, freestanding imaging center, mental
643 health facility, rehabilitation facility, skilled nursing facility and home health provider in the
644 payer's network, by type of provider, with hospital inpatient and outpatient prices listed
645 separately, and product type and determined using the method established under section 52 of
646 chapter 288 of the acts of 2010; (ix) hospital inpatient and outpatient costs, including direct and
647 indirect costs, according to a uniform methodology; (x) the annual rate of growth, stated as a
648 percentage, of the weighted average relative price by provider type and product type for the
649 payer's participating health care providers, whether that rate exceeds the rate of growth of the
650 applicable producer price index as reported by the United States Bureau of Labor Statistics and
651 identified by the commissioner of insurance and whether that rate exceeds the rate of growth in
652 projected economic growth benchmark established under section 7H½ of chapter 29; and (xi) a
653 comparison of relative prices for the payer's participating health care providers by provider type
654 which shows the weighted average relative price, the extent of variation in price, stated as a
655 percentage and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per
656 cent above and more than 10 per cent, 15 per cent and 20 per cent below the weighted average
657 relative price.

658 (d) The institute shall require the submission of data and other information from public
659 and private health care payers which utilize alternative payment contracts, including, but not

660 limited to: (i) the negotiated monthly budget for each alternative payment contract in the current
661 contract year; (ii) any applicable measures of provider performance in such alternative payment
662 contracts; and (iii) the average negotiated monthly budget weighted by member months for each
663 zip code.

664 For purposes of this subsection, payers shall report the negotiated monthly budget
665 assuming a neutral health status score of 1.0 using an industry accepted health status adjustment
666 tool and shall separately report the budget allowances for: all medical and behavioral health care
667 at both in and out-of-network providers; pharmacy coverage allowance; administrative expenses
668 such as data analytics, health information technology, clinical program development and other
669 program management fees; the purchase of reinsurance or stop-loss; risk reserves; and quality
670 bonus monies, unit cost adjustments or other special allowances. If out-of-network care,
671 behavioral health, stop-loss insurance or any other clinical services are carved out of any global
672 budget, bundled payments or other alternative payment methodologies such that there is no
673 allowance included in the budget for those services, payers shall report actual claims costs of
674 these items on a per member per month basis for the year immediately prior to the current
675 contract year.

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

679 Section 12. The institute shall ensure the timely reporting of information required under
680 sections 9, 10 and 11. The institute shall notify payers, providers and provider organizations of
681 any applicable reporting deadlines. The institute shall notify, in writing, a private health care

682 payer, provider or provider organization, which has failed to meet a reporting deadline and that
683 failure to respond within 2 weeks of the receipt of the notice may result in penalties. The institute
684 may assess a penalty against a payer, provider or provider organization that fails, without just
685 cause, to provide the requested information within 2 weeks following receipt of the written
686 notice required under this paragraph, of up to \$1,000 per week for each week of delay after the 2
687 week period following the payer's, provider's or provider organization's receipt of the written
688 notice; provided, however, that the maximum annual penalty against a private payer under this
689 section shall be \$50,000. Amounts collected under this section shall be deposited in the
690 Healthcare Payment Reform Fund.

691 Section 13. (a) The institute shall be the sole repository for health care data collected
692 under sections 9, 10 and 11. The institute shall collect, store and maintain such data in a payer
693 and provider claims database. The institute shall acquire, retain and oversee all information
694 technology, infrastructure, hardware, components, servers and employees necessary to carry out
695 this section. All other agencies, authorities, councils, boards and commissions of the
696 commonwealth seeking health care data that is collected under this section shall, whenever
697 feasible, utilize such data prior to requesting data directly from health care providers and payers.
698 In order to ensure patient data confidentiality, the institute shall not contract or transfer the
699 operation of the database or its functions to a third-party entity, nonprofit organization or
700 governmental entity; provided, however, that the institute may enter into interagency services
701 agreements for transfer and use of the data.

702 The institute shall, to the extent feasible, make data in the payer and provider claims
703 database available to payers and providers in real-time; provided, that all such data-sharing

704 complies with applicable state and federal privacy laws. The institute may charge a fee for real-
705 time access to such data.

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

714 Section 14. The institute shall, before adopting reporting regulations under this chapter,
715 consult with other agencies of the commonwealth and the federal government, affected
716 providers, provider organizations and affected payers, as applicable, to ensure that the reporting
717 requirements imposed under the regulations are not duplicative or excessive. If reporting
718 requirements imposed by the institute result in additional costs for the reporting providers, these
719 costs may be included in any rates promulgated by the executive office of health and human
720 services or a governmental unit designated by the executive office for these providers. The
721 institute may specify categories of information which may be furnished under an assurance of
722 confidentiality to the provider; provided that such assurance shall only be furnished if the
723 information is not to be used for setting rates.

724 Section 15. (a) The institute shall publish an annual report based on the information
725 submitted under sections 9, 10 and 11 concerning health care provider, provider organization and

726 private and public health care payer costs and cost trends. The institute shall compare such costs
727 and cost trends with the health care cost growth benchmark established by the health care quality
728 and finance authority under section 5 of chapter 176S and shall detail: (i) baseline information
729 about cost, price, quality, utilization and market power in the commonwealth's health care
730 system; (ii) factors that contribute to cost growth within the commonwealth's health care system
731 and to the relationship between provider costs and payer premium rates; (iii) the impact of health
732 care reform efforts on health care costs including, but not limited to, the development of limited
733 and tiered networks, increased price transparency, increased utilization of electronic medical
734 records and other health technology and increased prevalence of alternative payment contracts
735 and provider organizations with integrated care networks; (iv) price variance between providers
736 and any efforts undertaken by payers to reduce such variance; (v) trends in utilization of
737 unnecessary or duplicative services, with particular emphasis on imaging and other high-cost
738 services (vi) the prevalence and trends in adoption of alternative payment methodologies and
739 impact of alternative payment methodologies on overall health care spending, insurance
740 premiums and provider rates; and (vii) the development and status of provider organizations in
741 the commonwealth including, but not limited to, the formation of provider organizations with
742 integrated care networks, acquisitions, mergers, consolidations and any evidence of excess
743 consolidation or anti-competitive behavior by provider organizations.

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

748 (b) The attorney general may review and analyze any information submitted to the
749 institute under said sections 9, 10 and 11. The attorney general may require that any provider,
750 provider organization or payer produce documents, answer interrogatories and provide testimony
751 under oath related to health care costs and cost trends or documents that the attorney general
752 considers necessary to evaluate factors that contribute to cost growth within the commonwealth's
753 health care system and to the relationship between provider costs and payer premium rates. The
754 attorney general shall keep confidential all nonpublic information and documents obtained under
755 this section and shall not disclose such information or documents to any person without the
756 consent of the provider or payer that produced the information or documents except in a public
757 hearing under section 6 of chapter 176S, a rate hearing before the division of insurance or in a
758 case brought by the attorney general, if the attorney general believes that such disclosure will
759 promote the health care cost containment goals of the commonwealth and that such disclosure
760 should be made in the public interest after taking into account any privacy, trade secret or anti-
761 competitive considerations. Such confidential information and documents shall not be public
762 records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4
763 or section 10 of chapter 66.

764 (c) The institute shall participate in the annual hearing required by section 6 of chapter
765 176S and advise and assist the health care quality and finance authority in conducting such
766 hearing including, but not limited to, identifying witnesses and examining and cross-examining
767 providers, provider organizations and payers regarding any issues material to the subject of such
768 hearings.

769 (d) The institute shall provide technical assistance to the health care quality and finance
770 authority, in compiling the annual report required by section 6 of chapter 176S including, but not

771 limited to, providing access to any data collected by the institute under sections 9, 10 and 11 and
772 providing analysis regarding spending trends and factors underlying such spending trends.

773 Section 16. The institute shall perform ongoing analysis of data it receives under sections
774 9, 10 and 11 to identify any payers, providers or provider organizations whose increase in health
775 status adjusted total medical expense is considered excessive and who threaten the ability of the
776 state to meet the health care cost growth benchmark established by the health care quality and
777 finance authority under section 5 of chapter 176S. The institute shall confidentially provide a list
778 of such payers, providers and provider organizations to the health care quality and finance
779 authority such that the authority may pursue further action under section 7 of chapter 176S.

780 Section 17. (a) No provider organization may negotiate network contracts with any
781 carrier or third-party administrator except for provider organizations which are registered under
782 this chapter and regulations promulgated under this chapter; provided, however, that nothing in
783 this chapter shall require a provider organization which receives, or which represents providers
784 who collectively receive, less than \$1,000,000 in annual net patient service revenue from carriers
785 or third-party administrators and which has fewer than 10 affiliated physicians to be registered if
786 such provider organization does not accept risk contracts. No specialty hospital may be
787 registered to negotiate network contracts with any carrier or third-party administrator as part of a
788 provider organization that includes health care facilities that are not on the specialty hospital's
789 license or health care professionals that are not employed by the specialty hospital.

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

793 Section 18. The institute shall review and comment upon all capital expenditure projects
794 requiring a determination of need under section 25C of chapter 111, including, but not limited to,
795 the availability and accessibility of services similar to those provided, or proposed to be
796 provided, through the provider organization within its primary service areas and dispersed
797 service areas; the provider organization's impact on competing options for the delivery of health
798 care services within its primary service areas and dispersed service areas; less costly or more
799 effective alternative financing methods for such projects; the immediate and long-term financial
800 feasibility of such projects; the probable impact of the project on costs of and charges for
801 services; and the availability of funds for capital and operating needs. The institute shall transmit
802 to the department of public health its written recommendations on each project which shall
803 become part of the written record compiled by said department during its review of such project.
804 The institute shall appear and comment on any application for a determination of need where a
805 public hearing is required under said section 25C of said chapter 111. To carry out this
806 paragraph, the institute shall appoint a senior professional employee to act as a liaison with said
807 department.

808 Section 19. The institute shall establish a continuing program of investigation and study
809 of the uninsured and underinsured in the commonwealth, including the health insurance needs of
810 the residents of the geographically isolated or rural areas of the commonwealth. Said continuing
811 investigation and study shall examine the overall impact of programs developed by the institute
812 and the division of medical assistance on the uninsured, the underinsured and the role of
813 employers in assisting their employees in affording health insurance.

814 Section 20. The institute shall, in consultation with the health care quality and finance
815 authority, maintain a consumer health information website. The website shall contain

816 information comparing the quality, price and cost of health care services and may also contain
817 general health care information as the institute considers appropriate. The website shall be
818 designed to assist consumers in making informed decisions regarding their medical care and
819 informed choices among health care providers. Information shall be presented in a format that is
820 understandable to the average consumer. The institute shall take appropriate action to publicize
821 the availability of its website.

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

833 The institute shall, after due consideration and public hearing, adopt the reporting plan
834 and adopt or reject any revisions. If the institute rejects the reporting plan or any revisions, the
835 institute shall state its reasons for the rejection. The reporting plan and any revisions adopted by
836 the institute shall be promulgated by the institute. The institute shall submit the reporting plan
837 and any periodic revisions to the chairs of the house and senate committees on ways and means

838 and the chairs of the joint committee on health care financing and the clerks of the house and
839 senate.

840 The website shall provide updated information on a regular basis, at least annually, and
841 additional comparative quality, price and cost information shall be published as determined by
842 the institute. To the extent possible, the website shall include: (i) comparative quality
843 information by facility, clinician or physician group practice for each service or category of
844 service for which comparative price and cost information is provided; (ii) general information
845 related to each service or category of service for which comparative information is provided; (iii)
846 comparative quality information by facility, clinician or physician practice that is not service-
847 specific, including information related to patient safety and satisfaction; and (iv) data concerning
848 healthcare-acquired infections and serious reportable events reported under section 51H of
849 chapter 111.

850 Section 21. The institute shall coordinate with the public health council and the boards of
851 registration for health care providers to develop a uniform and interoperable electronic system of
852 public reporting for providers as a condition of licensure. The uniform provider licensure
853 reporting system shall include information designed for health resource planning and for analysis
854 of market share by provider organization by primary service areas and dispersed service areas,
855 including, but not limited to, reporting for each licensed provider its principal business locations;
856 the categories of services provided; the provider organization with which the provider is
857 affiliated for contracting purposes, or by which the provider is employed, if any; whether and to
858 what extent the provider is practicing on license; and such other factors as the institute deems
859 appropriate. The institute may centralize the uniform provider licensure reporting system or
860 create a central portal for public access to the uniform provider licensure information.

861 Section 22. Any provider of health care services that receives reimbursement or payment
862 for treatment of injured workers under chapter 152 and any provider of health care services other
863 than an acute or non-acute hospital that receives reimbursement or payment from any
864 governmental unit for general health supplies, care and rehabilitative services and
865 accommodations, shall, as a condition of such reimbursement or payment: (1) permit the
866 executive director, or the executive director's designated representative and the attorney general
867 or a designee, to examine such books and accounts as may reasonably be required for the
868 institute to perform its duties; (2) file with the executive director from time to time or on request,
869 such data, statistics, schedules or other information as the institute may reasonably require,
870 including outcome data and such information regarding the costs, if any, of such provider for
871 research in the basic biomedical or health delivery areas or for the training of health care
872 personnel which are included in the provider's charges to the public for health care services,
873 supplies and accommodations; and (3) accept reimbursement or payment at the rates established
874 by the secretary of health and human services or a governmental unit designated by the executive
875 office, subject to a right of appeal under section 13E of chapter 118E, as discharging in full any
876 and all obligations of an eligible person and the governmental unit to pay, reimburse or
877 compensate the provider of health care services in any way for general health supplies, care and
878 rehabilitative services or accommodations provided.

879 Any provider of health care services that knowingly fails to file with the institute data,
880 statistics, schedules or other information required under this section or by any regulation
881 promulgated by the institute or knowingly falsifies the same shall be punished by a fine of not
882 less than \$100 nor more than \$500.

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

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

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

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

900 SECTION 17. Said section 8H of said chapter 26, as so appearing, is hereby further
901 amended by striking out, in lines 56, 77 and 78, each time they appear, the words
902 “uncompensated care pool under section 18 of chapter 118G” and inserting in place thereof, in
903 each instance, the following words:- health safety net under chapter 118E .

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

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

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

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

913 (b) On or before January 15, the secretary of administration and finance shall meet with
914 the house and senate committees on ways and means and shall jointly develop a projected
915 economic growth benchmark for the ensuing calendar year which shall be agreed to by the
916 secretary and said committees. In developing a projected economic growth benchmark the
917 secretary and said committees, or subcommittees of said committees, may hold joint hearings on
918 the economy of the commonwealth; provided, however, that in the first year of the term of office
919 of a governor who has not served in the preceding year, said parties shall agree to the projected
920 economic growth benchmark not later than January 31 of said year. The secretary and the
921 committees may agree to incorporate this hearing into any consensus tax revenue forecast
922 hearing held under section 5B. The projected economic growth benchmark shall be included
923 with the consensus tax revenue forecast joint resolution under said section 5B and placed before
924 the members of the general court for their consideration. Such joint resolution, if passed by both
925 branches of the general court, shall establish the projected economic growth benchmark to be

926 used by the health care quality and finance authority to establish the health care cost growth
927 benchmark under section 5 of chapter 176S.

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

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

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

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

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

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

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

956 The secretary of labor and workforce development as trustee, shall administer the fund.
957 The secretary, in consultation with the Health Care Workforce Advisory Board established in
958 subsection (c), shall make expenditures from this account consistent with the subsections (e) and
959 (f); provided, that not more than 15 per cent of the amounts held in the fund in any 1 year shall
960 be used by the secretary for the combined cost of program administration, technical assistance to
961 grantees and program evaluation.

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

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

967 The board shall consist of the following members: the secretary of labor and workforce
968 development, who shall serve as chair; the executive director of the institute of health care
969 finance and policy or a designee; the commissioner of public health or a designee, and no more

970 than 13 members who shall be appointed by the secretary of labor and workforce development
971 and who shall reflect a broad distribution of diverse perspectives on the health care system and
972 health care workforce needs, including health care professionals, labor organizations, educational
973 institutions, consumer representatives, providers and payers.

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

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

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

982 (ii) address critical workforce shortages;

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

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

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

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

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

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

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

996 (e) The secretary shall establish a competitive grant process funded by the Health Care
997 Workforce Transformation Fund to eligible applicants to provide education and training to health
998 care workers. Eligible applicants shall include: employers and employer associations; local
999 workforce investment boards; labor organizations; joint labor-management partnerships;
1000 community-based organizations; institutions of higher education; vocational education
1001 institutions; one-stop career centers; local workforce development entities; and any partnership
1002 or collaboration between eligible applicants. Expenditures from the fund for such purposes shall
1003 complement and not replace existing local, state, private, or federal funding for training and
1004 educational programs.

1005 (f) A grant proposal submitted under subsection (e) shall include, but not be limited to:

1006 (i) a plan that defines specific goals for health care workforce training and
1007 educational improvements over a multi-year period in specific areas;

1008 (ii) the evidence-based programs the applicant shall use to meet the goals;

1009 (iii) a budget necessary to implement the plan, including a detailed description of
1010 any funding or in-kind contributions the applicant or applicants will be providing in support of
1011 the proposal;

1012 (iv) any other private funding or private sector participation the applicant
1013 anticipates in support of the proposal; and

1014 (v) the anticipated number of individuals who would receive a benefit due to the
1015 implementation of the plan.

1016 Priority may be given to proposals that target areas of critical labor needs for the health
1017 care industry or that are projected to be critical labor needs of the health care industry in the near
1018 future. Priority may also be given to proposals that target geographic areas with specific health
1019 care workforce needs or that target geographic areas with unemployment levels higher than the
1020 state average. If no proposals were offered in areas of particular need, the secretary may
1021 provide technical assistance and planning grant funding directly to eligible applicants in order to
1022 develop grant proposals.

1023 The secretary shall, in consultation with the Health Care Workforce Advisory Board,
1024 develop guidelines for an annual review of the progress being made by each grantee. Each
1025 grantee shall participate in any evaluation or accountability process implemented by or
1026 authorized by the secretary.

1027 (g) The comptroller shall annually transfer not less than 10% of available funds in the
1028 Health Care Workforce Transformation Trust to the department of public health to support the
1029 health care provider workforce loan repayment program, established in section 25N of chapter
1030 111.

1031 (h) The comptroller shall annually transfer not less than 10% of available funds in the
1032 Health Care Workforce Transformation Trust Fund to the Massachusetts Nursing and Allied
1033 Health Workforce Development Trust Fund established in section 33 of chapter 305 of the acts
1034 of 2008 to develop and support strategies that increase the number of public higher education
1035 faculty members and students who participate in programs that support careers in fields related to
1036 nursing and allied health.

1037 (i) The secretary shall, annually on or before January 31, report on expenditures from the
1038 Health Care Workforce Transformation Trust Fund. The report shall include, but shall not be
1039 limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable
1040 to the administrative costs of the secretary of labor and workforce development; (iii) an itemized
1041 list of the funds expended through the competitive grant process and a description of the grantee
1042 activities; and (iv) the results of the evaluation of the effectiveness of the activities funded
1043 through grants. The report shall be provided to the chairs of the house and senate committees on
1044 ways and means, the joint committee on public health, the joint committee on health care
1045 financing and the joint committee on labor and workforce development and shall be posted on
1046 the department of public health's website. (j) The secretary of labor and workforce
1047 development may promulgate appropriate regulations to carry out this section.

1048 SECTION 24. Section 1 of chapter 29D of the General Laws, as so appearing, is hereby
1049 amended by striking out, in line 13, the words "25 and 26 of chapter 118G" and inserting in
1050 place thereof the following words:- 63 of chapter 118E.

1051 SECTION 25. Section 3 of said chapter 29D, as so appearing, is hereby amended by
1052 striking out, in line 18, the words “25 and 26 of chapter 118G” and inserting in place thereof the
1053 following words:- 63 of chapter 118E.

1054 SECTION 26. Said section 3 of said chapter 29D, as so appearing, is hereby amended by
1055 striking out, in line 22, the words “25 and 26 of said chapter 118G” and inserting in place thereof
1056 the following words:- 63 of said chapter 118E.

1057 SECTION 27. Section 1 of chapter 32 of the General Laws, as so appearing, is hereby
1058 amended by inserting after the word “connector”, in line 216, the following words:- the health
1059 care quality and finance authority.

1060 SECTION 28. Section 2 of chapter 32A of the General Laws, as so appearing, is hereby
1061 amended by inserting after the word “authority”, in line 12, the following words:- the health care
1062 quality and finance authority.

1063 SECTION 29. Chapter 40J of the General Laws is hereby amended by striking out
1064 sections 6D and 6E, as so appearing, and inserting in place thereof the following 2 sections:-

1065 Section 6D. (a) There shall be established an institute for health care innovation,
1066 technology and competitiveness, to be known as the Massachusetts e-Health Institute. The
1067 executive director of the corporation shall appoint a qualified individual to serve as the director
1068 of the institute, who shall be an employee of the corporation, report to the executive director and
1069 manage the affairs of the institute. The institute shall advance the dissemination of health
1070 information technology across the commonwealth, including the deployment of interoperable
1071 electronic health records systems in all health care provider settings that are networked through a
1072 statewide health information exchange.

1073 (b) There shall be established a health information technology council within the
1074 corporation. The council shall advise the institute on the dissemination of health information
1075 technology across the commonwealth, including the deployment of interoperable electronic
1076 health records systems in all health care provider settings that are networked through a statewide
1077 health information exchange.

1078 The council shall consist of 15 members: 1 of whom shall be the secretary of
1079 administration and finance, who shall serve as chair; 1 of whom shall be the secretary of health
1080 and human services; 1 of whom shall be the executive director of the institute of health care
1081 finance and policy or a designee; 1 of whom shall be the secretary of housing and economic
1082 development or a designee; 11 of whom shall be appointed by the governor, of whom at least 1
1083 shall be an expert in health information technology, 1 of whom shall be an expert in state and
1084 federal health privacy laws, 1 of whom shall be an expert in the health policy, 1 of whom shall
1085 be an expert in health information technology relative to privacy and security, 1 of whom shall
1086 be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom
1087 shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of
1088 whom shall be from a physician group practice, and 2 of whom shall represent the health
1089 insurance carriers. The council may consult with such parties, public or private, as it deems
1090 desirable in exercising its duties under this section, including persons with expertise and
1091 experience in the development and dissemination of interoperable electronic health records
1092 systems, and the implementation of interoperable electronic health record systems by small
1093 physician groups or ambulatory care providers, as well as persons representing organizations
1094 within the commonwealth interested in and affected by the development of networks and
1095 interoperable electronic health records systems, including, but not limited to, persons

1096 representing local public health agencies, licensed hospitals and other licensed facilities and
1097 providers, private purchasers, the medical and nursing professions, physicians, health insurers
1098 and health plans, the state quality improvement organization, academic and research institutions,
1099 consumer advisory organizations with expertise in health information technology and other
1100 stakeholders as identified by the secretary of health and human services. Appointive members of
1101 the council shall serve for terms of 2 years or until a successor is appointed. Members shall be
1102 eligible to be reappointed and shall serve without compensation.

1103 The members of the council shall be deemed to be directors for purposes of the fourth
1104 paragraph of section 3. Chapter 268A shall apply to all council members except that the council
1105 may purchase from, sell to, borrow from, contract with or otherwise deal with any organization
1106 in which any council member is in anyway interested or involved; provided, however, that such
1107 interest or involvement shall be disclosed in advance to the council and recorded in the minutes
1108 of the proceedings of the council; and provided further, that no member shall be deemed to have
1109 violated section 4 of said chapter 268A because of such member's receipt of the member's usual
1110 and regular compensation from the member's employer during the time in which the member
1111 participates in the activities of the council.

1112 (c) The institute, in consultation with the council, shall advance the dissemination of
1113 health information technology and support the state's efforts in meeting the health care cost
1114 growth benchmark established under section 5 of chapter 176S by: (i) facilitating the
1115 implementation and use of interoperable electronic health records systems by health care
1116 providers in order to improve health care delivery and coordination, reduce unwarranted
1117 treatment variation, eliminate wasteful paper-based processes, help facilitate chronic disease
1118 management initiatives and establish transparency; (ii) facilitating the creation and maintenance

1119 of a statewide interoperable electronic health records network that allows individual health care
1120 providers in all health care settings to exchange patient health information with other
1121 providers;(iii) identifying and promoting an accelerated dissemination in the commonwealth of
1122 emerging health care technologies that have been developed and employed and that are expected
1123 to improve health care quality and lower health care costs, but that have not been widely
1124 implemented in the commonwealth, including, but not limited to, evidence-based clinical
1125 decision support tools for advanced diagnostic imaging services; (iv) facilitating health care
1126 providers in achieving and maintaining compliance with the standards for meaningful use,
1127 beyond stage 1, established by regulation by the United States Department of Health and Human
1128 Services under the Health Information Technology for Economic and Clinical Health Act and
1129 referred to in this section as “meaningful use”; and (v) promoting to patients, providers and the
1130 general public, a broad understanding of the benefits of interoperable electronic health records
1131 systems for care delivery, care coordination, improved quality and ultimately greater cost
1132 efficiency in the health care delivery system.

1133 (d) The institute director shall prepare and annually update a statewide electronic health
1134 records plan. Each plan shall contain a budget for the application of funds from the e-Health
1135 Institute Fund for use in implementing each such plan. The institute director shall submit such
1136 plans and updates, and associated budgets, to the council for its review and comment. Each such
1137 plan and the associated budget shall be subject to approval of the board following consideration
1138 on it by the council.

1139 Components of each such plan, as updated, shall be community-based implementation
1140 plans that assess a municipality’s or region’s readiness to implement and use electronic health
1141 record systems and an interoperable electronic health records network within the referral market

1142 for a defined patient population. Each such implementation plan shall address the development,
1143 implementation and dissemination of interoperable electronic health records systems among
1144 health care providers in the community or region, particularly providers, such as community
1145 health centers that serve underserved populations, including, but not limited to, racial, ethnic and
1146 linguistic minorities, uninsured persons and areas with a high proportion of public payer care.

1147 Each plan as updated shall: (i) allow seamless, secure electronic exchange of health
1148 information among health care providers, health plans and other authorized users; (ii) provide
1149 consumers with secure, electronic access to their own health information; (iii) meet all applicable
1150 federal and state privacy and security requirements, including requirements imposed by 45
1151 C.F.R. §§ 160, 162 and 164; (iv) meet standards for interoperability adopted by the institute after
1152 consultation with the council; (v) give patients the option of allowing only designated health care
1153 providers to disseminate their individually identifiable information; (vi) provide public health
1154 reporting capability as required under state law; (vii) support any activities funded by the
1155 Healthcare Payment Reform Fund; and (viii) allow reporting of health information other than
1156 identifiable patient health information for purposes of such activities as the secretary of health
1157 and human services may consider necessary.

1158 (e) The corporation may contract with implementing organizations to: (i) facilitate a
1159 public-private partnership that includes representation from hospitals, physicians and other
1160 health care professionals, health insurers, employers and other health care purchasers, health data
1161 and service organizations and consumer organizations; (ii) provide resources and support to
1162 recipients of grants awarded under subsection (f) to implement each program within the
1163 designated community pursuant to the implementation plan; (iii) certify and disburse funds to
1164 subcontractors, when necessary; (iv) provide technical assistance to facilitate successful practice

1165 redesign, adoption of electronic health records and utilization of care management strategies; (v)
1166 ensure that electronic health records systems are fully interoperable and secure and that sensitive
1167 patient information is kept confidential by exclusively utilizing electronic health records
1168 products that are certified by the Office of the National Coordinator under the federal Health
1169 Information Technology for Economic and Clinical Health Act; and (vi) certify, with approval of
1170 the corporation, a group of subcontractors who shall provide the necessary hardware and
1171 software for system implementation. Prior to the institute's issuing requests for proposals for
1172 contracts to be entered into under this section, the institute's director shall consult with the
1173 council with respect to the content of all such proposals.

1174 (f) Funding for the institute and council's activities shall be through the e-Health Institute
1175 Fund, established in section 6E. The institute, in consultation with the council, shall develop
1176 mechanisms for funding health information technology, including a grant program to assist
1177 health care providers with costs associated with health information technologies, including
1178 electronic health records systems, and coordinated with other electronic health records projects
1179 seeking federal reimbursement. Providers eligible for receipt of amounts from the Fund shall be
1180 limited to (i) any individual or institutional provider of health care services that is not in a
1181 category of individual or institutional provider eligible to receive Medicare or Medicaid
1182 incentive payments under the federal Health Information Technology for Economic and Clinical
1183 Health Act, such payments being referred to in this subsection as "incentive payments," and that
1184 lack access, as reasonably determined by the director of the institute, to resources needed to
1185 implement interoperable electronic health records systems that satisfy standards established by
1186 the institute; and (ii) physicians, hospitals and community health centers that are eligible for
1187 incentive payments but lack access, as reasonably determined by the director of the institute, to

1188 resources needed to support their meeting meaningful use standards as determined in accordance
1189 with the federal Health Information Technology for Economic and Clinical Health Act.
1190 Individual or institutional providers under clause (i) may include, but shall not be limited to,
1191 mental health facilities, chronic care and rehabilitation hospitals, skilled nursing facilities,
1192 visiting nursing associations, home health providers, registered nurses, licensed practical nurses,
1193 physicians, physician assistants, chiropractors, dentists, occupational therapists, physical
1194 therapists, optometrists, pharmacists, podiatrists, psychologists and social workers. In making the
1195 determinations regarding available resources as described in clauses (i) and (ii), the director of
1196 the institute shall consider:

1197 (1) the demonstrated need for investment, taking into account all resources
1198 available to the particular provider including the relationship or affiliation of the particular
1199 provider to a health care delivery system and the capacity of such system to provide financial
1200 support for the provider's meeting the standards established by the institute or meaningful use
1201 standards;

1202 (2) the anticipated return on investment, as measured by improved health care
1203 coordination, reduction in health care costs, reduction in unwarranted treatment variation and
1204 elimination of wasteful paper-based processes;

1205 (3) the amount of financial or in-kind support the particular provider will commit
1206 to supplementing or supporting any investment by the corporation;

1207 (4) whether there is a reasonable likelihood that the provider's use of such
1208 amounts will achieve the long term benefits expected from implementing an interoperable
1209 electronic health records system;

1210 (5) whether the investment will support innovative health care delivery and
1211 payment models as identified by the health care quality and finance authority;

1212 (6) whether the investment will support efforts to integrate mental health and
1213 substance abuse services with overall medical care;

1214 (7) the extent to which the investment will support efforts to meet the health care
1215 cost benchmark established by the health care quality and finance authority; and

1216 (8) any other factors that the director determines are appropriate.

1217 The institute shall consult with the office of Medicaid to maximize all opportunities to
1218 qualify any expenditures for federal financial participation. Applications for funding shall be in
1219 the form and manner determined by the institute director, and shall include the information and
1220 assurances required by the institute director. The institute director may consider, as a condition
1221 for awarding grants, the grantee's financial participation and any other factors it deems relevant.

1222 All grants shall be recommended by the institute director and subsequently approved by
1223 the executive director. The institute director shall work with implementation organizations to
1224 oversee the grant-making process as it relates to an implementing organization's responsibilities
1225 under its contract with the corporation. Each recipient of monies from this program shall: (i)
1226 capture and report certain quality improvement data, as determined by the institute in
1227 consultation with the department of public health and the institute of health care finance and
1228 policy; (ii) fully implement an electronic health record system, including all clinical features,
1229 with such interoperability as may be feasible at the time, not later than the second year of the
1230 grant; and (iii) make use of the system's full range of features. In the event that any recipient of
1231 grant monies from this program does not achieve installation of a fully functioning electronic

1232 health record system or does not achieve the appropriate level of interoperability within the 2
1233 year grant period, such recipient shall be required to repay to the corporation all or some portion,
1234 as determined by the corporation, of the grant funds previously provided to such recipient under
1235 this section.

1236 (g) The institute shall establish a pilot partnership with community colleges or vocational
1237 technology schools in the commonwealth to support health information technology curriculum
1238 development and workforce development. Any funding for such a program from the e-Health
1239 Institute Fund shall be recommended by the institute director and approved by the executive
1240 director.

1241 (h) The council shall receive staff assistance from the corporation.

1242 (i) The institute shall file an annual report, not later than January 30, with the joint
1243 committee on health care financing, the joint committee on economic development and emerging
1244 technologies and the house and senate committees on ways and means concerning the activities
1245 of the council in general and, in particular, describing the progress to date in implementing a
1246 statewide interoperable electronic health records system and recommending such further
1247 legislative action as it deems appropriate.

1248 Section 6E. (a) There shall be established and set up on the books of the corporation a
1249 separate fund to be known as the e-Health Institute Fund, referred to in this section as the fund.
1250 There shall be credited to the fund revenue from appropriations or other monies authorized by
1251 the general court and specifically designated to be credited to the fund, including but not limited
1252 to, amounts to be credited to the fund under subsection (a) of section 70 of chapter 118E, any
1253 investment income earned on the fund's assets and all other sources. The corporation shall hold

1254 the fund in an account or accounts separate from other funds, including other funds established
1255 under this chapter. Amounts credited to the fund shall be available for reasonable expenditure by
1256 the corporation, without further appropriation, for any and all activities consistent with this
1257 section and supportive of the purposes specified in section 6D, including but not limited to, in the
1258 form of grants, contracts, loans and such other vehicles as the corporation may determine are
1259 appropriate. Amounts credited to the fund shall be expended or applied only with the approval
1260 of the executive director of the corporation upon consultation with the director of the institute as
1261 provided in this section. No amounts credited to the fund shall be applied to the
1262 commonwealth's match for federal funds for which a state match is required unless the federal
1263 funds to be matched are allocated to the corporation for use to further the purposes set out in this
1264 section, as reasonably determined by the executive director of the corporation; provided that
1265 there are no other sources of funds available to meet federal matching requirements in order to
1266 secure such federal funds, as reasonably determined by the executive director of the corporation.
1267 Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert
1268 to the General Fund and shall be available for expenditure in the following fiscal year.

1269 SECTION 30. Section 8B of chapter 62C of the General Laws, as so appearing, is hereby
1270 amended by striking out, in line 28, the word "division", the second time it appears, and inserting
1271 in place thereof the following word:- institute.

1272 SECTION 31. Clause (22) of subsection (b) of section 21 of said chapter 62C, as so
1273 appearing, is hereby amended by striking out, in lines 141 and 142, the words "division of health
1274 care finance and policy" and inserting in place thereof the following words:- executive office of
1275 health and human services.

1276 SECTION 32. Said clause (22) of said subsection (b) of said section 21 of said chapter
1277 62C, as so appearing, is hereby further amended by striking out, in line 143, the word “118G”
1278 and inserting in place thereof the following word:- 118E.

1279 SECTION 33. Clause (23) of said subsection (b) of said section 21 of said chapter 62C,
1280 as so appearing, is hereby amended by striking out, in line 145, the words “division of health
1281 care finance and policy” and inserting in place thereof the following words:- executive office of
1282 health and human services.

1283 SECTION 34. Said clause (23) of said subsection (b) of said section 21 of said chapter
1284 62C, as so appearing, is hereby further amended by striking out, in lines 48 and 49, the words
1285 “section 39 of chapter 118G” and inserting in place thereof the following words:- section 69 of
1286 chapter 118E.

1287 SECTION 35. Section 1 of chapter 62D of the General Laws, as amended by section 13
1288 of chapter 142 of the acts of 2011, is hereby amended by striking out, in lines 8 to 10, the words
1289 “the division of health care finance and policy in the exercise of its duty to administer the
1290 uncompensated care pool pursuant to chapter 118G” and inserting in place thereof the following
1291 words:- the executive office of health and human services in the exercise of its duty to administer
1292 the Health Safety Net Trust Fund under chapter 118E.

1293 SECTION 36. Said section 1 of said chapter 62D, as so amended, is hereby further
1294 amended by striking out the words “division of health care finance and policy on behalf of the
1295 uncompensated care pool by a person or a guarantor of a person who received free care services
1296 paid for in whole or in part by the uncompensated care pool or on whose behalf the
1297 uncompensated care pool paid for emergency bad debt, pursuant to subsection (m) of section 18

1298 of chapter 118G” and inserting in place thereof the following words:- executive office of health
1299 and human services on behalf of the Health Safety Net Trust Fund by a person or a guarantor of
1300 a person who received free care services paid for in whole or in part by the Health Safety Net
1301 Trust Fund or on whose behalf said fund paid for emergency bad debt.

1302 SECTION 37. Said section 1 of said chapter 62D, as so amended, is hereby further
1303 amended by striking out, in line 55, the words “section 39 of chapter 118G” and inserting in
1304 place thereof the following words:- section 69 of chapter 118E.

1305 SECTION 38. Section 8 of said chapter 62D, as appearing in the 2010 Official Edition, is
1306 hereby amended by striking out the second paragraph.

1307 SECTION 39. Section 10 of said chapter 62D, as so appearing, is hereby amended by
1308 striking out, in lines 8 and 9, the words “the division of medical assistance, the corporation, the
1309 office of the state comptroller, and the division of health care finance and policy” and inserting
1310 in place thereof the following words:- the office of medicaid, the corporation, the office of the
1311 state comptroller and the executive office of health and human services.

1312 SECTION 40. Section 13 of said chapter 62D, as amended by section 14 of chapter 142
1313 of the acts of 2011, is hereby further amended by striking out the words “section 39 of chapter
1314 118G” and inserting in place thereof the following words:- section 69 of chapter 118E.

1315 SECTION 41. Section 3 of chapter 62E of the General Laws, as appearing in the 2010
1316 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words “division of
1317 health care finance and policy” and inserting in place thereof the following words:- executive
1318 office of health and human services.

1319 SECTION 42. Section 12 of said chapter 62E, as so appearing, is hereby amended by
1320 striking out, in lines 19 and 20, the words “division of health care finance and policy” and
1321 inserting in place thereof the following words:- executive office of health and human services.

1322 SECTION 43. Said section 12 of said chapter 62E, as so appearing, is hereby amended by
1323 striking out, in lines 21 to 22, the words “sections 34 to 39, inclusive, of chapter 118G and
1324 sections 6B, 6C and 18B of chapter 118G” and inserting in place thereof the following words:-
1325 sections 64 to 69, inclusive, of chapter 118E and sections 17 and 18 of chapter 176Q.

1326 SECTION 44. Section 17A of chapter 66 of the General Laws, as so appearing, is hereby
1327 amended by striking out, in line 11, the word “118G” and inserting in place thereof the following
1328 word:- 118E.

1329 SECTION 45. Section 3 of chapter 71B of the General Laws, as so appearing, is hereby
1330 amended by striking out, in line 177, the words “2A of chapter 118G” and inserting in place
1331 thereof the following words:- 13C of chapter 118E.

1332 SECTION 46. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby
1333 amended by striking out the definition of “Board of health” and inserting in place thereof the
1334 following 2 definitions:-

1335 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health
1336 care provider for health care services provided to an insured.

1337 “Board of health”, shall include the board or officer having like powers and duties in
1338 towns where there is no board of health.

1339 SECTION 47. Said section 1 of said chapter 111, as so appearing, is hereby further
1340 amended by striking out the definition of “Medical peer review committee” or “committee”, and
1341 inserting in place thereof the following definition:-

1342 “Medical peer review committee” or “committee”, a committee of health care providers,
1343 which functions to: (i) evaluate or improve the quality of health care rendered by providers of
1344 health care services; (ii) determine whether health care services were performed in compliance
1345 with the applicable standards of care; (iii) determine whether the costs of health care services
1346 were performed in compliance with the applicable standards of care; (iv) determine whether the
1347 cost of the health care services rendered were considered reasonable by the providers of health
1348 services in the area; (v) determine whether a health care provider’s actions call into question
1349 such health care provider’s fitness to provide health care services; or (vi) evaluate and assist
1350 health care providers impaired or allegedly impaired by reason of alcohol, drugs, physical
1351 disability, mental instability or otherwise; provided further, that “medical peer review
1352 committee” shall also include: (i) a committee of a pharmacy society or association that is
1353 authorized to evaluate the quality of pharmacy services or the competence of pharmacists and
1354 suggest improvements in pharmacy systems to enhance patient care; or (ii) a pharmacy peer
1355 review committee established by a person or entity that owns a licensed pharmacy or employs
1356 pharmacists that is authorized to evaluate the quality of pharmacy services or the competence of
1357 pharmacists and suggest improvements in pharmacy systems to enhance patient care.

1358 SECTION 48. Said chapter 111 is hereby further amended by inserting after section 2F
1359 the following 2 sections:-

1360 Section 2G. (a) There shall be established and set upon the books of the commonwealth a
1361 separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without
1362 further appropriation, by the department of public health. The fund shall consist of health system
1363 benefit surcharge revenues collected by the commonwealth under section 68 of chapter 118E,
1364 public and private sources such as gifts, grants and donations to further community-based
1365 prevention activities, interest earned on such revenues and any funds provided from other
1366 sources.

1367 The commissioner of public health, as trustee, shall administer the fund. The
1368 commissioner, in consultation with the Prevention and Wellness Advisory Board established
1369 under section 2H, shall make expenditures from the fund consistent with subsections (d) and (e);
1370 provided, that not more than 15 per cent of the amounts held in the fund in any 1 year shall be
1371 used by the department for the combined cost of program administration, technical assistance to
1372 grantees or program evaluation.

1373 (b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall
1374 not revert to the General Fund and shall be available for expenditure in the following fiscal year.

1375 (c) All expenditures from the Prevention and Wellness Trust Fund shall support the
1376 state's efforts to meet the health care cost growth benchmark established in section 5 of chapter
1377 176S and any activities funded by the Healthcare Payment Reform Fund, and 1 or more of the
1378 following purposes: (i) reduce rates of the most prevalent and preventable health conditions; (ii)
1379 increase healthy behaviors; (iii) increase the adoption of workplace-based wellness or health
1380 management programs that result in positive returns on investment for employees and

1381 employers; (iv) address health disparities; or (v) develop a stronger evidence-base of effective
1382 prevention programming.

1383 (d) The commissioner shall annually award not less than 75 per cent of the Prevention
1384 and Wellness Trust Fund through a competitive grant process to municipalities, community-
1385 based organizations, health care providers, and health plans that apply for the implementation,
1386 evaluation and dissemination of evidence-based community preventive health activities. To be
1387 eligible to receive a grant under this subsection, a recipient shall be: (i) a municipality or group
1388 of municipalities working in collaboration; (ii) a community-based organization working in
1389 collaboration with 1 or more municipalities; or (iii) a health care provider or a health plan
1390 working in collaboration with 1 or more municipalities and a community-based organization.
1391 Expenditures from the fund for such purposes shall supplement and not replace existing local,
1392 state, private or federal public health-related funding.

1393 (e) A grant proposal submitted under subsection (d) shall include, but not be limited to:
1394 (i) a plan that defines specific goals for the reduction in preventable health conditions and health
1395 care costs over a multi-year period; (ii) the evidence-based programs the applicant shall use to
1396 meet the goals; (iii) a budget necessary to implement the plan, including a detailed description of
1397 any funding or in-kind contributions the applicant or applicants will be providing in support of
1398 the proposal; (iv) any other private funding or private sector participation the applicant
1399 anticipates in support of the proposal; and (v) the anticipated number of individuals that would
1400 be affected by implementation of the plan.

1401 Priority may be given to proposals in a geographic region of the state with a higher than
1402 average prevalence of preventable health conditions, as determined by the commissioner of

1403 public health, in consultation with the Prevention and Wellness Advisory Board. If no proposals
1404 were offered in areas of the state with particular need, the department shall ask for a specific
1405 request for proposal for that specific region. If the commissioner determines that no suitable
1406 proposals have been received, such that the specific needs remain unmet, the department may
1407 work directly with municipalities or community-based organizations to develop grant proposals.

1408 The department of public health shall, in consultation with the Prevention and Wellness
1409 Advisory Board, develop guidelines for an annual review of the progress being made by each
1410 grantee. Each grantee shall participate in any evaluation or accountability process implemented
1411 or authorized by the department.

1412 (f) The commissioner of public health may annually expend not more than 10 per cent of
1413 the Prevention and Wellness Trust Fund to support the increased adoption of workplace-based
1414 wellness or health management programming. The department of public health shall expend
1415 such funds for activities including, but not limited to: (i) developing and distributing
1416 informational tool-kits for employers, including a model wellness guide developed by the
1417 department; (ii) providing technical assistance to employers implementing wellness programs;
1418 (iii) hosting informational forums for employers; (iv) promoting awareness of wellness tax
1419 credits provided through the state and federal government, including the wellness subsidy
1420 provided by the commonwealth health connector authority; (v) public information campaigns
1421 that quantify the importance of healthy lifestyles, disease prevention, care management and
1422 health promotion programs; and (vi) providing a stipend to employers to help start, grow or
1423 maintain wellness programs.

1424 The department of public health shall develop guidelines to annually review progress
1425 toward increasing the adoption of workplace-based wellness or health management
1426 programming.

1427 (g) The department of public health shall, annually on or before January 31, report on
1428 expenditures from the Prevention and Wellness Trust Fund. The report shall include, but not be
1429 limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable
1430 to the administrative costs of the department of public health; (iii) an itemized list of the funds
1431 expended through the competitive grant process and a description of the grantee activities; (iv)
1432 the results of the evaluation of the effectiveness of the activities funded through grants; and (v)
1433 an itemized list of expenditures used to support workplace-based wellness or health management
1434 programs. The report shall be provided to the chairs of the house and senate committees on ways
1435 and means and the joint committee on public health and shall be posted on the department of
1436 public health's website.

1437 (h) The department of public health shall, under the advice and guidance of the
1438 Prevention and Wellness Advisory Board, annually report on its strategy for administration and
1439 allocation of the fund, including relevant evaluation criteria. The report shall set forth the
1440 rationale for such strategy, including, but not limited to: (i) a list of the most prevalent
1441 preventable health conditions in the commonwealth, including health disparities experienced by
1442 populations based on race, ethnicity, gender, disability status, sexual orientation or socio-
1443 economic status; (ii) a list of the most costly preventable health conditions in the commonwealth;
1444 (iii) a list of evidence-based or promising community-based programs related to the conditions
1445 identified in clauses (i) and (ii); and (iv) a list of evidence-based workplace wellness programs or
1446 health management programs related to the conditions in clauses (i) and (ii). The report shall

1447 recommend specific areas of focus for allocation of funds. If appropriate, the report shall
1448 reference goals and best practices established by the National Prevention and Public Health
1449 Promotion Council and the Centers for Disease Control and Prevention, including, but not
1450 limited to the national prevention strategy, the healthy people report and the community
1451 prevention guide.

1452 (i) The department of public health may promulgate regulations to carry out this section.

1453 Section 2H. There shall be a Prevention and Wellness Advisory Board to make
1454 recommendations to the commissioner concerning the administration and allocation of the
1455 Prevention and Wellness Trust Fund established in section 2G, establish evaluation criteria and
1456 perform any other functions specifically granted to it by law.

1457 The board shall consist 15 members: 1 of whom shall be the commissioner of public
1458 health or a designee, who shall serve as chair; 1 of whom shall be the executive director of the
1459 institute of health care finance and policy established in chapter 12C or a designee; 1 of whom
1460 shall be the secretary of health and human services or a designee; 12 of whom shall be appointed
1461 by the governor, 1 of whom shall be a person with expertise in the field of public health
1462 economics; 1 of whom shall be a person with expertise in public health research; 1 of whom
1463 shall be a person with expertise in the field of health equity; 1 of whom shall be a person from a
1464 local board of health for a city or town with a population greater than 50,000; 1 of whom shall be
1465 a person of a board of health for a city or town with a population less than 50,000; 2 of whom
1466 shall be representatives of health insurance carriers; 1 of whom shall be a person from a
1467 consumer health organization; 1 of whom shall be a person from a hospital association; 1 of
1468 whom shall be a person from a statewide public health organization; 1 of whom shall be a

1469 representative of the interest of businesses; and 1 of whom shall be a person from an association
1470 representing community health workers.

1471 SECTION 49. Section 4H of chapter 111 of the General Laws, as appearing in the 2010
1472 Official Edition, is hereby amended by striking out, in line 20, the words “division of health care
1473 finance and policy” and inserting in place thereof the following words:- executive office of
1474 health and human services, or a governmental unit designated by the executive office.

1475 SECTION 50. Said chapter 111 is hereby further amended by striking out section 25A, as
1476 so appearing, and inserting in place thereof the following section:-

1477 Section 25A. (a) Every 4 years the department of public health, in consultation with the
1478 institute of health care finance and policy, shall submit to the governor and the general court a 4-
1479 year health resource plan. The plan shall identify needs of the commonwealth in health care
1480 services, providers, programs and facilities; the resources available to meet those needs; and the
1481 priorities for addressing those needs on a statewide basis.

1482 (1) The plan shall include the location, distribution and nature of all health care
1483 resources in the commonwealth and shall establish and maintain on a current basis an inventory
1484 of all such resources together with all other reasonably pertinent information concerning such
1485 resources. For purposes of this section, a health care resource shall include any resource, whether
1486 personal or institutional in nature and whether owned or operated by any person, the
1487 commonwealth or political subdivision thereof, the principal purpose of which is to provide, or
1488 facilitate the provision of, services for the prevention, detection, diagnosis or treatment of those
1489 physical and mental conditions experienced by humans which usually are the result of, or result
1490 in, disease, injury, deformity, or pain.

1491 The plan shall identify certain categories of health care resources, including acute care
1492 units; non-acute care units; specialty care units, including, but not limited to, burn, coronary care,
1493 cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal
1494 dialysis and surgical, including trauma, intensive care units; skilled nursing facilities; home
1495 health and mental health services; treatment and prevention services for alcohol and other drug
1496 abuse; emergency care; ambulatory care services; primary care resources; pharmacy and
1497 pharmacological services; family planning services; allied health services including, but not
1498 limited to, optometric care, chiropractic services, dental care, midwifery services; federally
1499 qualified health centers and free clinics; numbers of technologies or equipment defined as
1500 innovative services or new technologies by the department under section 25C; and health
1501 screening and early intervention services.

1502 (2) The plan shall make recommendations for the appropriate supply and
1503 distribution of resources, programs, capacities, technologies and services identified in paragraph
1504 (1) based on an assessment of need for the next 4 years and options for implementing such
1505 recommendations and mechanisms. The recommendations shall reflect at least the following
1506 goals: to maintain and improve the quality of health care services; to support the state's efforts to
1507 meet the health care cost growth benchmark established under section 5 of chapter 176S; to
1508 support innovative health care delivery and alternative payment models as identified by the
1509 health care quality and finance authority; to reduce unnecessary duplication; to support universal
1510 access to community-based preventative and patient-centered primary health care; to reduce
1511 health disparities; to support efforts to integrate mental health and substance abuse services with
1512 overall medical care; to reflect the latest trends in utilization and support the best standards of
1513 care; and to rationally distribute health care resources across geographic regions of state based on

1514 the needs of the population on a statewide basis as well as the needs of particular geographic
1515 areas of the state.

1516 (b) To prepare the plan, the commissioner shall assemble an advisory committee of no
1517 more than 13 members who shall reflect a broad distribution of diverse perspectives on the
1518 health care system, including health care professionals, third-party payers, both public and
1519 private, and consumer representatives. The advisory committee shall review drafts and provide
1520 recommendations to the commissioner during the development of the plan.

1521 The department, with the advisory committee, shall conduct at least 5 public hearings, in
1522 different regions of the state, on the plan as proposed and shall give interested persons an
1523 opportunity to submit their views orally and in writing. In addition, the department may create
1524 and maintain a website to allow members of the public to submit comments electronically and
1525 review comments submitted by others.

1526 The department shall develop a mechanism for receiving ongoing public comment
1527 regarding the plan and for revising it every 4 years or as needed.

1528 (c) The department shall issue guidelines, rules, or regulations consistent with the state
1529 health plan for making determinations of need. If the commissioner determines that statutory
1530 changes are necessary to implement the plan, the commissioner shall submit legislative language
1531 to the joint committee on public health and the joint committee on health care financing.

1532 (d) The inventory compiled under subsection (a) and all related information shall be
1533 maintained in a form usable by the general public in a designated office of the department, shall
1534 constitute a public record and shall be coordinated with information collected by the department
1535 under other provisions of law, federal census information and other vital statistics from reliable

1536 sources; provided, however, that any item of information which is confidential or privileged in
1537 nature or under any other provision of law shall not be regarded as a public record under this
1538 section.

1539 (e) The department may require health care resources to provide information for the
1540 purposes of this section and may prescribe by regulation uniform reporting requirements. In
1541 prescribing such regulations the department shall strive to make any reports required under this
1542 section of mutual benefit to those providing as well as those using such information and shall
1543 avoid placing any burdens on such providers which are not reasonably necessary to accomplish
1544 this section.

1545 Agencies of the commonwealth which collect cost or other data concerning health care
1546 resources shall cooperate with the department in coordinating such data with information
1547 collected under this section.

1548 (f) The department shall publish analyses, reports and interpretations of information
1549 collected under this section to promote awareness of the distribution and nature of health care
1550 resources in the commonwealth.

1551 (g) In the performance of its duties, the department, subject to appropriation, may enter
1552 into such contracts with agencies of the federal government, the commonwealth or any political
1553 subdivision thereof and public or private bodies, as it deems necessary; provided, however, that
1554 no information received under such a contract shall be published or relied upon for any purpose
1555 by the department unless the department has determined such information to be reasonably
1556 accurate by statistical sampling or other suitable techniques for measuring the reliability of
1557 information-gathering processes.

1558 (h) The department of public health may establish an Amyotrophic Lateral Sclerosis
1559 registry, by areas and regions of the commonwealth, with specific data to be obtained from
1560 urban, low and median income communities and minority communities of the commonwealth.

1561 SECTION 51. Section 25B of said chapter 111, as so appearing, is hereby amended by
1562 striking out, in lines 23 and 24, the words "1 of chapter 118G" and inserting in place thereof the
1563 following words:- 8 of chapter 118E.

1564 SECTION 52. Said chapter 111 is hereby further amended by striking out section 25C, as
1565 so appearing, and inserting in place thereof the following section:-

1566 Section 25C. (a) Notwithstanding any general or special law to the contrary, except as
1567 provided in section 25 C½, no person or agency of the commonwealth or any political
1568 subdivision thereof shall make substantial capital expenditures for construction of a health care
1569 facility or substantially change the service of such facility unless there is a determination by the
1570 department that there is need for such construction or change. No such determination of need
1571 shall be required for any substantial capital expenditure for construction or any substantial
1572 change in service which shall be related solely to the conduct of research in the basic biomedical
1573 or applied medical research areas and shall at no time result in any increase in the clinical bed
1574 capacity or outpatient load capacity of a health care facility and shall at no time be included
1575 within or cause an increase in the gross patient service revenue of a facility for health care
1576 services, supplies and accommodations, as such revenue shall be defined under section 31 of
1577 chapter 6A. Any person undertaking any such expenditure related solely to such research which
1578 shall exceed or may reasonably be regarded as likely to exceed \$150,000 or any such change in
1579 service solely related to such research, shall give written notice of the expenditure or change in

1580 service to the department and the institute of health care finance and policy at least 60 days
1581 before undertaking such expenditure or change in service. Said notice shall state that such
1582 expenditure or change shall be related solely to the conduct of research in the basic biomedical or
1583 applied medical research areas and shall at no time be included within or result in any increase in
1584 the clinical bed capacity or outpatient load capacity of a facility and shall at no time cause an
1585 increase in the gross patient service revenue, as defined in under said section 31 of said chapter
1586 6A, of a facility for health care services, supplies and accommodations; provided, however, that
1587 if it is subsequently determined that there was a violation of this section, the applicant may be
1588 punished by a fine of not more than three times the amount of such expenditure or value of said
1589 change of service.

1590 (b) Notwithstanding subsection (a), a determination of need shall be required for any such
1591 expenditure or change if the notice required by this section is not filed in accordance with the
1592 requirements of this section or if the department finds, after receipt of said notice, that such
1593 expenditure or change will not be related solely to research in the basic biomedical or applied
1594 medical research areas, will result in an increase in the clinical bed capacity or outpatient load
1595 capacity of a facility or will be included within or cause an increase in the gross patient service
1596 revenues of a facility. A research exemption granted under this section shall not be deemed to be
1597 evidence of need in any determination of need proceeding.

1598 (c) No person or agency of the commonwealth or any political subdivision thereof shall
1599 provide an innovative service or use a new technology, in any location other than in a health care
1600 facility, unless the person or agency first is issued a determination of need for such innovative
1601 service or new technology by the department.

1602 (d) No person or agency of the commonwealth or any political subdivision thereof shall
1603 acquire for location in other than a health care facility a unit of medical, diagnostic, or
1604 therapeutic equipment, other than equipment used to provide an innovative service or which is a
1605 new technology, with a fair market value in excess of \$150,000 unless the person or agency
1606 notifies the department of the person's or agency's intent to acquire such equipment and of the
1607 use that will be made of the equipment. Such notice shall be made in writing and shall be
1608 received by the department at least 30 days before contractual arrangements are entered into to
1609 acquire the equipment with respect to which notice is given. A determination by the department
1610 of need for such equipment shall be required for any such acquisition (i) if the notice required by
1611 this subsection is not filed in accordance with the requirements of this subsection; and (ii) if the
1612 requirements for exemption under subsection (a) of section 25 C½ are not met; provided,
1613 however, that in no event shall any person who acquires a unit of magnetic resonance imaging
1614 equipment for location other than in a health care facility refer or influence any referrals of
1615 patients to said equipment, unless said person is a physician directly providing services with that
1616 equipment; provided, however, that for the purposes of this section, no public advertisement
1617 shall be deemed a referral or an influence of referrals; and provided, further, that any person who
1618 has an ownership interest in said equipment, whether direct or indirect, shall disclose said
1619 interest to patients utilizing said equipment in a conspicuous manner.

1620 (e) Each person or agency operating a unit of equipment described in this section shall
1621 submit annually to the department information and data in connection with utilization and
1622 volume rates of said equipment on a form or forms prescribed by the department.

1623 (f) Except as provided in section 25 C½, no person or agency of the commonwealth or
1624 any political subdivision thereof shall acquire an existing health care facility unless the person or

1625 agency notifies the department of the person's or agency's intent to acquire such facility and of
1626 the services to be offered in the facility and its bed capacity. Such notice shall be made in writing
1627 and shall be received by the department at least 30 days before contractual arrangements are
1628 entered into to acquire the facility with respect to which the notice is given. A determination of
1629 need shall be required for any such acquisition if the notice required by this subsection is not
1630 filed in accordance with the requirements of this subsection or if the department finds, within 30
1631 days after receipt of notice under this subsection, that the services or bed capacity of the facility
1632 will be changed in being acquired.

1633 (g) In making any such determination, the department shall encourage appropriate
1634 allocation of private and public health care resources and the development of alternative or
1635 substitute methods of delivering health care services so that adequate health care services will be
1636 made reasonably available to every person within the commonwealth at the lowest reasonable
1637 aggregate cost, shall take into account any comments from the institute of health care finance and
1638 policy pursuant to section 17 of chapter 12C, and shall take into account the special needs and
1639 circumstances of HMOs. The department shall also recognize the special needs and
1640 circumstances of projects that (1) are essential to the conduct of research in basic biomedical or
1641 health care delivery areas or to the training of health care personnel; (2) are deemed consistent
1642 with the recommendations of the state health resource plan filed by the department under section
1643 25A; (3) are unlikely to result in any increase in the clinical bed capacity or outpatient load
1644 capacity of the facility; and (4) are unlikely to cause an increase in the total patient care charges
1645 of the facility to the public for health care services, supplies and accommodations, as such
1646 charges shall be defined under section 5 of chapter 409 of the acts of 1976.

1647 (h) Applications for such determination shall be filed with the department, together with
1648 such other forms and information as shall be prescribed by, or acceptable to, the department. A
1649 duplicate copy of any application together with supporting documentation for such application,
1650 shall be a public record and kept on file in the department. The department may require a public
1651 hearing on any application. A reasonable fee, established by the department, shall be paid upon
1652 the filing of such application; provided, that in no event shall such fee exceed .1 per cent of the
1653 capital expenditures, if any, proposed by the applicant. The department may also require the
1654 applicant to provide an independent cost-analysis, conducted at the expense of the applicant, to
1655 demonstrate that the application is consistent with the commonwealth's efforts to meet the health
1656 care cost-containment goals established by the health care quality and finance authority.

1657 (i) Except in the case of an emergency situation determined by the department as
1658 requiring immediate action to prevent further damage to the public health or to a health care
1659 facility, the department shall not act upon an application for such determination unless: (1) the
1660 application has been on file with the department for at least 30 days; (2) the institute of health
1661 care finance and policy, the state and appropriate regional comprehensive health planning
1662 agencies and, in the case of long-term care facilities only, the department of elder affairs, have
1663 been provided copies of such application and supporting documents and given reasonable
1664 opportunity to comment on such application; and (3) a public hearing has been held on such
1665 application when requested by the applicant, the state or appropriate regional comprehensive
1666 health planning agency or any 10 taxpayers of the commonwealth. If, in any filing period, an
1667 individual application is filed which would implicitly decide any other application filed during
1668 such period, the department shall not act only upon an individual.

1669 (j) The department shall so approve or disapprove in whole or in part each such
1670 application for a determination of need within 8 months after filing with the department;
1671 provided that the department may, on 1 occasion only, delay such action for up to 2 months after
1672 the applicant has provided information which the department reasonably has requested during
1673 such 8 month period. Applications remanded to the department by the health facilities appeals
1674 board under section 25E shall be acted upon by the department within the same time limits
1675 provided in this section for the department to approve or disapprove applications for a
1676 determination of need. If an application has not been acted upon by the department within such
1677 time limits, the applicant may, within a reasonable period of time, bring an action in the nature of
1678 mandamus in the superior court to require the department to act upon the application.

1679 (k) Determinations of need shall be based on the written record compiled by the
1680 department during its review of the application and on such criteria consistent with sections 25B
1681 to 25G, inclusive, as were in effect on the date of filing of the application. In compiling such
1682 record the department shall confine its requests for information from the applicant to matters
1683 which shall be within the normal capacity of the applicant to provide. In each case the action by
1684 the department on the application shall be in writing and shall set forth the reasons for such
1685 action; and every such action and the reasons for such action shall constitute a public record and
1686 be filed in the department.

1687 (l) The department shall stipulate the period during which a determination of need shall
1688 remain in effect, which in no event shall originally be longer than 3 years but which may be
1689 extended by the department for cause shown. Any such determination shall continue to be
1690 effective only upon the applicant: (i) making reasonable progress toward completing the
1691 construction or substantial change in services for which need was determined to exist; (ii)

1692 complying with all other laws relating to the construction, licensure and operation of health care
1693 facilities; and (iii) complying with such further terms and conditions as the department
1694 reasonably shall require.

1695 (m) The department shall notify the secretary of elder affairs forthwith of the pendency of
1696 any proceeding, of any public hearing and of any action to be taken under this section on any
1697 application submitted by or on behalf of any long-term care facility.

1698 (n) No long-term care facility located in an under-bedded urban area shall be replaced or
1699 the license for said facility transferred outside an under-bedded urban area. For the purposes of
1700 this subsection, an under-bedded urban area shall mean a city or town in which: (i) the per capita
1701 income is below the state average; (ii) the percentage of the population below 100 per cent of the
1702 federal poverty level is above the state average; or (iii) the percentage of the population below
1703 200 per cent of the federal poverty level is above the state average.

1704 SECTION 53. Said chapter 111 is hereby further amended by striking out section 25L, as
1705 amended by section 114 of chapter 3 of the acts of 2011, and inserting in place thereof the
1706 following section:-

1707 Section 25L. There shall be in the department a health care provider workforce center to
1708 improve access to health and behavioral health care services. The center, in consultation with the
1709 healthcare provider workforce advisory council established by section 25M and the secretary of
1710 labor and workforce development, shall: (i) coordinate the department's health care workforce
1711 activities with other state agencies and public and private entities involved in health care
1712 workforce training, recruitment and retention, including with the activities of the Health Care
1713 Workforce Transformation Fund; (ii) monitor trends in access to primary care providers, nurse

1714 practitioners practicing as primary care providers, behavioral health providers, and other
1715 physician and nursing providers, through activities including: (1) review of existing data and
1716 collection of new data as needed to assess the capacity of the health care and behavioral health
1717 care workforce to serve patients, including patient access and regional disparities in access to
1718 physicians or nurses and behavioral health professionals and to examine physician and nursing
1719 and behavioral health professionals' satisfaction; (2) review existing laws, regulations, policies,
1720 contracting or reimbursement practices and other factors that influence recruitment and retention
1721 of physicians and nurses and behavioral health professionals; (3) making projections on the
1722 ability of the workforce to meet the needs of patients over time; (4) identifying strategies
1723 currently being employed to address workforce needs, shortages, recruitment and retention; (5)
1724 studying the capacity of public and private medical, nursing and behavioral health professional
1725 schools in the commonwealth to expand the supply of primary care physicians, nurse
1726 practitioners practicing as primary care providers, and licensed behavioral health professionals;
1727 (iii) establish criteria to identify underserved areas in the commonwealth for administering the
1728 loan repayment program established under section 25N and for determining statewide target
1729 areas for health care provider placement based on the level of access; and (iv) address health care
1730 workforce shortages by: (1) coordinating state and federal loan repayment and incentive
1731 programs for health care providers; (2) providing assistance and support to communities,
1732 physician groups, community health centers, community based behavioral health organizations
1733 and community hospitals in developing cost-effective and comprehensive recruitment initiatives;
1734 (3) maximizing all sources of public and private funds for recruitment initiatives; (4) designing
1735 pilot programs and make regulatory and legislative proposals to address workforce needs,
1736 shortages, recruitment and retention; and (5) making short-term and long-term programmatic and

1737 policy recommendations to improve workforce performance, address identified workforce
1738 shortages and recruit and retain physicians, nurses and behavioral health professionals.

1739 (b) The center shall communicate and coordinate with the institute for health care finance
1740 and policy, established by section 16K of chapter 6A, the health care quality and finance
1741 authority, the secretary of labor and workforce development, and the health disparities council,
1742 established by section 16O of said chapter 6A.

1743 (c) The center shall annually submit a report, not later than March 1, to the governor; and
1744 the general court, by filing the report with the clerks of the house of representatives and the
1745 senate, the joint committee on labor and workforce development, the joint committee on health
1746 care financing and the joint committee on public health. The report shall include: (i) data on
1747 patient access and regional disparities in access to physicians, by specialty and sub-specialty,
1748 behavioral health professionals and nurses; (ii) data on factors influencing recruitment and
1749 retention of physicians, nurses and behavioral health professionals; (iii) short and long-term
1750 projections of physicians, nurses and behavioral health professionals supply and demand; (iv)
1751 strategies being employed by the council or other entities to address workforce needs, shortages,
1752 recruitment and retention; (v) recommendations for designing, implementing and improving
1753 programs or policies to address workforce needs, shortages, recruitment and retention; and (vi)
1754 proposals for statutory or regulatory changes to address workforce needs, shortages, recruitment
1755 and retention.

1756 SECTION 54. Said chapter 111 is hereby further amended by striking out sections 25M
1757 and 25N, as appearing in the 2010 Official Edition, and inserting in place thereof the following 2
1758 sections:-

1759 Section 25M. (a) There shall be a healthcare provider workforce advisory council within,
1760 but not subject to the control of, the health care provider workforce center established by section
1761 25L. The council shall advise the center on the capacity of the healthcare workforce to provide
1762 timely, effective, culturally competent, quality physician, nursing and behavioral health services.

1763 (b) The council shall consist of 16 members, 1 of whom shall be the commissioner of
1764 public health, who shall serve as chair; 3 of whom who shall be appointed by the governor: 1 of
1765 whom shall be a physician with a primary care specialty designation; 1 of whom shall be an
1766 advanced practice nurse, authorized under section 80B of said chapter 112; 1 of whom shall be a
1767 behavioral health professional; and 1 person from each of the following organizations who shall
1768 be appointed by the secretary of health and human services from a list of nominees submitted by
1769 the organization: the Association for Behavioral Healthcare; the Massachusetts Psychological
1770 Association; the Massachusetts Association of Social Workers; the Massachusetts Extended Care
1771 Federation; the Massachusetts Organization of Nurse Executives; the Massachusetts Academy of
1772 Family Physicians; the Massachusetts League of Community Health Centers, Inc.; the
1773 Massachusetts Medical Society; the Massachusetts Nurses Association; the Massachusetts
1774 Association of Registered Nurses; the Massachusetts Hospital Association, Inc.; and Health Care
1775 For All, Inc. Members of the council shall be appointed for a term of 3 years or until a successor
1776 is appointed. Members shall be eligible to be reappointed and shall serve without compensation,
1777 but may be reimbursed for actual and necessary expenses reasonably incurred in the performance
1778 of their duties. Vacancies of unexpired terms shall be filled within 60 days by the appropriate
1779 appointing authority.

1780 The council shall meet at least bimonthly, at other times as determined by its rules and
1781 when requested by any 8 members.

1782 (c) The council shall advise the center on: (i) trends in access to primary care and
1783 physician subspecialties, nursing and behavioral health services; (ii) the development and
1784 administration of the loan repayment program, established under section 25N, including criteria
1785 to identify underserved areas in the commonwealth; (iii) solutions to address identified health
1786 care workforces shortages; and (iv) the center's annual report to the general court.

1787 Section 25N. (a) There shall be a health care provider workforce loan repayment
1788 program, administered by the health care provider workforce center established by section 25L.
1789 The program shall provide repayment assistance for medical school loans to participants who: (i)
1790 are graduates of medical or nursing schools; (ii) specialize in family health or medicine, internal
1791 medicine, pediatrics, psychiatry, obstetrics/gynecology, mental health or substance use disorder
1792 treatment; (iii) demonstrate competency in health information technology, including use of
1793 electronic medical records, computerized physician order entry and e-prescribing; and (iv) meet
1794 other eligibility criteria, including service requirements, established by the board. Each recipient
1795 shall be required to enter into a contract with the commonwealth which shall obligate the
1796 recipient to perform a term of service of not less than 2 years in medically underserved areas as
1797 determined by the center.

1798 (b) The center shall promulgate regulations for the administration and enforcement of this
1799 section which shall include penalties and repayment procedures if a participant fails to comply
1800 with the service contract.

1801 The center shall, in consultation with the health care workforce advisory council and the
1802 public health council, establish criteria to identify medically underserved areas within the
1803 commonwealth. These criteria shall consist of quantifiable measures, which may include the

1804 availability of primary care medical services or behavioral health services within reasonable
1805 traveling distance, poverty levels and disparities in health care access or health outcomes.

1806 (c) The center shall evaluate the program annually, including exit interviews of
1807 participants to determine their post-program service plans and to solicit program improvement
1808 recommendations.

1809 (d) The center shall file an annual report, not later than July 1, with the governor, the
1810 clerks of the house of representatives and the senate, the house and senate committees on ways
1811 and means, the joint committee on health care financing, the joint committee on mental health
1812 and substance abuse and the joint committee on public health. The report shall include annual
1813 data and historical trends of: (i) the number of applicants, the number accepted and the number
1814 of participants by race, gender, medical or nursing specialty, medical or nursing school,
1815 residence prior to medical or nursing school and where they plan to practice after program
1816 completion; (ii) the service placement locations and length of service commitments by
1817 participants; (iii) the number of participants who fail to fulfill the program requirements and the
1818 reason for the failures; (iv) the number of former participants who continue to serve in
1819 underserved areas; and (v) program expenditures.

1820 SECTION 55. Section 51 of said chapter 111, as so appearing, is hereby amended by
1821 striking out, in lines 25 and 26, the words “division of health care finance and policy” and
1822 inserting in place thereof the following words:- commonwealth health insurance connector.

1823 SECTION 56. Said section 51 of said chapter 111, as so appearing, is hereby further
1824 amended by striking out, in lines 25, 36 and 46, the word “division” and inserting in place
1825 thereof, in each instance, the following word:- institute.

1826 SECTION 57. Said section 51 of said chapter 111, as so appearing, is hereby further
1827 amended by striking out, in lines 27 and 28, the words “pursuant to section 18 of chapter 118G”.

1828 SECTION 58. Section 51G of said chapter 111, as so appearing, is hereby amended by
1829 inserting after the words “or services,” in line 38, the following words:- conduct a public hearing
1830 on the closure of said essential services or of the hospital. The department shall.

1831 SECTION 59. Subsection (c) of section 51H of said chapter 111, as so appearing, is
1832 hereby amended by striking out, in lines 70 and 71, the words “and to the health care quality and
1833 cost council”.

1834 SECTION 60. Said chapter 111 is hereby further amended by inserting after section 51H
1835 the following section:-

1836 Section 51I. (a) As used in this section the following words shall, unless the context
1837 clearly requires otherwise, have the following meanings:-

1838 “Adverse event”, injury to a patient resulting from a medical intervention, and not to the
1839 underlying condition of the patient.

1840 “Checklist of care”, pre-determined steps to be followed by a team of healthcare
1841 providers before, during and after a given procedure to decrease the possibility of patient harm
1842 by standardizing care.

1843 “Facility,” a hospital, institution maintaining an Intensive Care Unit, institution providing
1844 surgical services or clinic providing ambulatory surgery.

1845 (b) The department shall encourage the development and implementation of checklists of
1846 care that prevent adverse events and reduce healthcare-associated infection rates. The department

1847 shall develop model checklists of care, which may be implemented by facilities; provided
1848 however, that facilities may develop and implement checklists independently.

1849 (c) Facilities shall report data and information relative to their use or non-use of
1850 checklists to the department and the Betsy Lehman center for patient safety and medical error
1851 reduction. The department may consider facilities that use similar programs to be in compliance.
1852 Reports shall be made in the manner and form established by the department. Individual reports
1853 shall be kept confidential by the department and the Betsy Lehman center, but aggregated
1854 compliance rates shall be posted publicly.

1855 SECTION 61. Said chapter 111 is hereby further amended by inserting, after section
1856 53G, the following section:-

1857 Section 53H. No hospital shall enter into a contract or agreement, which creates or
1858 establishes a partnership, employment or any other professional relationship with a licensed
1859 physician that would prohibit or limit the ability of said physician to provide testimony in an
1860 administrative or judicial hearing, including cases of medical malpractice.

1861 SECTION 62. Section 62M of said chapter 111, as so appearing, is hereby amended by
1862 striking out, in line 13, the words “division of health care finance and policy” and inserting in
1863 place thereof the following words:- executive office of health and human services or a
1864 governmental unit designated by the executive office.

1865 SECTION 63. Section 67C of said chapter 111, as so appearing, is hereby amended by
1866 striking out, in line 8, the words “division of health care finance and policy” and inserting in
1867 place thereof the following words:- executive office of health and human services.

1868 SECTION 64. Section 69H of said chapter 111, as so appearing, is hereby amended by
1869 striking out, in lines 2 and 3, the words “division of health care finance and policy” and inserting
1870 in place thereof the following words:- executive office of health and human services or a
1871 governmental unit designated by the executive office.

1872 SECTION 65. Section 72P of said chapter 111, as so appearing, is hereby amended by
1873 striking out, in line 20, the word “division” and inserting in place thereof the following word:-
1874 institute.

1875 SECTION 66. Section 72Q of said chapter 111, as so appearing, is hereby amended by
1876 striking out, in line 2, the word “division” and inserting in place thereof the following word:-
1877 institute.

1878 SECTION 67. Section 72Y of said chapter 111, as so appearing, is hereby amended by
1879 striking out, in lines 43 and 47, the words “7 of chapter 118G” and inserting in place thereof, in
1880 each instance, the following words:- 13D of chapter 118E.

1881 SECTION 68. Section 78 of said chapter 111, as so appearing, is hereby amended by
1882 striking out, in lines 19 and 20, the words “division of health care finance and policy” and
1883 inserting in place thereof the following words:- executive office of health and human services or
1884 a governmental unit designated by the executive office.

1885 SECTION 69. Section 78A of said chapter 111, as so appearing, is hereby amended by
1886 striking out, in line 14, the words “division of health care finance and policy” and inserting in
1887 place thereof the following words:- executive office of health and human services or a
1888 governmental unit designated by the executive office.

1889 SECTION 70. Section 79 of said chapter 111, as so appearing, is hereby amended by
1890 striking out, in line 9, the words “division of health care finance and policy” and inserting in
1891 place thereof the following words:- executive office of health and human services or a
1892 governmental unit designated by the executive office.

1893 SECTION 71. Section 80 of said chapter 111, as so appearing, is hereby amended by
1894 striking out, in lines 5 and 6, the words “division of health care finance and policy” and inserting
1895 in place thereof the following words:- executive office of health and human services or a
1896 governmental unit designated by the executive office.

1897 SECTION 72. Said section 80 of said chapter 111, as so appearing, is hereby further
1898 amended by striking out, in line 8, the word “division” and inserting in place thereof the
1899 following words:- executive office.

1900 SECTION 73. Section 82 of said chapter 111, as so appearing, is hereby amended by
1901 striking out, in lines 22 and 23, the words “division of health care finance and policy” and
1902 inserting in place thereof the following words:- executive office of health and human services or
1903 a governmental unit designated by the executive office.

1904 SECTION 74. Said section 82 of said chapter 111, as so appearing, is hereby further
1905 amended by striking out, in line 24, the word “division” and inserting in place thereof the
1906 following words:- executive office.

1907 SECTION 75. Section 88 of said chapter 111, as so appearing, is hereby amended by
1908 striking out, in line 16, the words “division of health care finance and policy” and inserting in
1909 place thereof the following words:- executive office of health and human services or a
1910 governmental unit designated by the executive office.

1911 SECTION 76. Section 116A of said chapter 111, as so appearing, is hereby amended by
1912 striking out, in line 2, the words “division of health care finance and policy” and inserting in
1913 place thereof the following words:- executive office of health and human services or a
1914 governmental unit designated by the executive office.

1915 SECTION 77. Section 204 of said chapter 111, as so appearing, is hereby amended by
1916 adding the following subsection:-

1917 (f) This section shall apply to any committee formed by an individual or group to perform
1918 the duties or functions of medical peer review, notwithstanding the fact that the formation of the
1919 committee is not required by law or regulation or that the individual or group is not solely
1920 affiliated with a public hospital, licensed hospital, nursing home or health maintenance
1921 organization.

1922 SECTION 78. Section 217 of said chapter 111, as so appearing, is hereby amended by
1923 striking out, in lines 16 and 17, the words “the health plan report card developed pursuant to
1924 section 24 of chapter 118G”.

1925 SECTION 79. Subsection (a) of section 217 of said chapter 111, as so appearing, is
1926 hereby amended by striking out, in line 33, the word “and”.

1927 SECTION 80. Said subsection (a) of said section 217 of said chapter 111, as so
1928 appearing, is hereby further amended by adding the following 3 paragraphs:-

1929 (8) have the authority to promulgate regulations establishing safeguards to protect
1930 consumers from inappropriate denials of services or treatment in connection with utilization of
1931 any alternative payment methodologies, as defined in section 1 of chapter 12C;

1932 (9) have the authority to promulgate regulations, in consultation with the division of
1933 insurance, establishing safeguards against, and penalties for, inappropriate selection of low cost
1934 patients and avoidance of high cost patients by any provider or provider organization accepting
1935 alternative payment methodologies, as such terms are defined in section 1 of chapter 12C; and

1936 (10) regulate the appeals processes established in section 23 of chapter 176O and
1937 establish, by regulation, minimum standards for fair, fast and objective review of consumer
1938 grievances against provider organizations registered under section 10 of chapter 12C including,
1939 but not limited to, complaint and appeals processes regarding health care personnel, facilities,
1940 treatment quality, restrictions on patient choice and denials of services or treatments.

1941 SECTION 81. Said section 217 of said chapter 111, as so appearing, is hereby further
1942 amended by striking out, in lines 48 and 49, the words “the division of health care finance and
1943 policy pursuant to section 24 of chapter 118G” and inserting in place thereof the following
1944 words:- the institute of health care finance and policy.

1945 SECTION 82. Subsection (b) of said section 217 of said chapter 111, as so appearing, is
1946 hereby amended by adding the following 2 sentences:-

1947 The commissioner shall establish an external review process for the review of grievances
1948 submitted by or on behalf of patients of provider organizations registered under section 10 of
1949 chapter 12C and shall specify the maximum amount of time for the completion of a
1950 determination and review after a grievance is submitted. The department shall establish
1951 expedited review procedures applicable to emergency situations.

1952 SECTION 83. Said chapter 111 is hereby further amended by adding the following 2
1953 sections:-

1954 Section 225. (a) For the purposes of this section, the following words shall have the
1955 following meanings:—

1956 “Anatomic pathology service”, histopathology, surgical pathology, cytopathology,
1957 hematology, subcellular pathology, molecular pathology and blood-banking services performed
1958 by a pathologist.

1959 “Charge”, the uniform price for specific services within a revenue center of a hospital.

1960 “Cytopathology”, the examination of cells from the following:

1961 (i) fluids;

1962 (ii) aspirates;

1963 (iii) washings;

1964 (iv) brushings; or

1965 (v) smears, including the pap test examination performed by a physician or under
1966 the supervision of a physician.

1967 “Hematology”, the microscopic evaluation of bone marrow aspirates and biopsies
1968 performed by a physician or under the supervision of a physician, and peripheral blood smears
1969 when the attending or treating physician or technologist requests that a blood smear be reviewed
1970 by a pathologist.

1971 “Histopathology” or “surgical pathology”, the gross and microscopic examination of
1972 organ tissue performed by a physician or under the supervision of a physician.

1973 “Patient”, any natural person receiving health care services.

1974 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
1975 patient for a charge.

1976 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX
1977 programs, other governmental payers, insurance companies, health maintenance organizations
1978 and nonprofit hospital service corporations. Third party payer shall not include a purchaser
1979 responsible for payment for health care services rendered by a hospital, either to the purchaser or
1980 to the hospital.

1981 (b) A clinical laboratory or physician providing anatomic pathology services for patients
1982 in the commonwealth shall present or cause to be presented a claim, bill or demand for payment
1983 for these services only to the following:

1984 (i) the patient directly;

1985 (ii) the responsible insurer or other third-party payer;

1986 (iii) the hospital, public health clinic or nonprofit health clinic ordering such
1987 services;

1988 (iv) the referral laboratory or a physician’s office laboratory when the physician
1989 of such laboratory performs the anatomic pathology service; or

1990 (v) the governmental agency or its specified public or private agent, agency or
1991 organization on behalf of the recipient of the services.

1992 (c) Except as provided under this section, no licensed practitioner shall, directly or
1993 indirectly, charge, bill or otherwise solicit payment for anatomic pathology services unless the
1994 services were rendered personally by the licensed practitioner or under the licensed practitioner's
1995 direct supervision under section 353 of the Public Health Service Act, 42 U.S.C. § 263a.

1996 (d) No patient, insurer, third party payer, hospital, public health clinic or non-profit health
1997 clinic shall be required to reimburse any licensed practitioner for charges or claims submitted in
1998 violation of this section.

1999 (e) Nothing in this section shall be construed to mandate the assignment of benefits for
2000 anatomic pathology services.

2001 (f) Nothing in this section shall prohibit billing between laboratories for anatomic
2002 pathology services in instances where a sample must be sent to another specialist. Nothing in this
2003 section shall authorize a physician's office laboratory to bill for anatomic pathology services
2004 when the physician of such laboratory has not performed the anatomic pathology service.

2005 (g) The board of registration in medicine may revoke, suspend or deny renewal of the
2006 license of a practitioner who violates this section.

2007 Section 226. (a) Prior to an admission, procedure or service and upon request by a patient
2008 or prospective patient, a health care provider shall, within 2 working days, disclose the allowed
2009 amount or charge of the admission, procedure or service, including the amount for any facility
2010 fees required; provided, however, that if a health care provider is unable to quote a specific
2011 amount in advance due to the health care provider's inability to predict the specific treatment or
2012 diagnostic code, the health care provider shall disclose the estimated maximum allowed amount

2013 or charge for a proposed admission, procedure or service, including the amount for any facility
2014 fees required.

2015 (b) If a patient or prospective patient is covered by a health plan, a health care provider
2016 who participates as a network provider shall, upon request of a patient or prospective patient,
2017 provide notice of , based on the information available to the provider at the time of the request,
2018 sufficient information regarding the proposed admission, procedure or service for the patient or
2019 prospective patient to use and the applicable toll-free telephone number and website of the health
2020 plan established to disclose co-insurance, copayment and deductibles, under clause (3) of
2021 subsection (a) of section 6 of chapter 1760. A health care provider may assist a patient or
2022 prospective patient in using the health plan’s toll-free number and website.

2023 (c) The commissioner shall, in consultation with the board of registration in medicine,
2024 promulgate regulations to enforce this section. The commissioner may impose a fine of up to
2025 \$1000 for each violation of this section. A health care provider aggrieved by the issuance of a
2026 fine under this section may, within 21 days of receiving notification of the commissioner’s
2027 decision to impose such fine, request an adjudicatory hearing under chapter 30A.

2028 SECTION 84. Section 1 of chapter 111K of the General Laws, as appearing in the 2010
2029 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words “established by
2030 section 18 of chapter 118G”.

2031 SECTION 85. Section 10 of said chapter 111K, as so appearing, is hereby amended by
2032 striking out, in line 2, the word “division”, the second time it appears, and inserting in place
2033 thereof the following word:- institute.

2034 SECTION 86. Section 3 of chapter 111M of the General Laws, as so appearing, is hereby
2035 amended by striking out, in lines 10 and 11, the word “division” and inserting in place thereof, in
2036 each instance, the following word:- institute.

2037 SECTION 87. The first paragraph of section 2 of chapter 112 of the General Laws, as so
2038 appearing, is hereby amended by inserting after the second sentence the following 2 sentences:-
2039 The board shall require, as a standard of eligibility for licensure, that applicants demonstrate
2040 proficiency in the use of computerized physician order entry, e-prescribing, electronic health
2041 records and other forms of health information technology, as determined by the board; provided,
2042 that proficiency, at a minimum, shall mean that applicants demonstrate the skills to comply with
2043 the “meaningful use” requirements under 45 C.F.R. Part 170.

2044 SECTION 88. Chapter 112 of the General Laws, is hereby amended by inserting, after
2045 section 2C, the following section:-

2046 Section 2D. No physician shall enter into a contract or agreement, which creates or
2047 establishes a partnership, employment or any other form of professional relationship that
2048 prohibits a physician from providing testimony in an administrative or judicial hearing, including
2049 cases of medical malpractice.

2050 SECTION 89. Said chapter 112 is hereby further amended by inserting after section 80H
2051 the following section:-

2052 Section 80I. When a law or rule requires a signature, certification, stamp, verification,
2053 affidavit or endorsement by a physician, when relating to physical or mental health, that
2054 requirement may be fulfilled by a nurse practitioner practicing under section 80B. Nothing in
2055 this section shall be construed to expand the scope of practice of nurse practitioners. This

2056 section shall not be construed to preclude the development of mutually agreed upon guidelines
2057 between the nurse practitioner and supervising physician under section 80E.

2058 SECTION 90. Chapter 118E of the General Laws, as so appearing, is hereby amended by
2059 striking out section 8 and inserting in place thereof the following section:-

2060 Section 8. As used in this chapter the following terms and phrases shall, unless the
2061 context clearly requires otherwise, have the following meanings:

2062 “Actual costs”, all direct and indirect costs incurred by a hospital or a community health
2063 center in providing medically necessary care and treatment to its patients, determined in
2064 accordance with generally accepted accounting principles.

2065 “Acute hospital”, the teaching hospital of the University of Massachusetts Medical
2066 School and any hospital licensed under section 51 of chapter 111 and which contains a majority
2067 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of
2068 public health.

2069 “Case mix”, the description and categorization of a hospital’s patient population
2070 according to criteria approved by the institute including, but not limited to, primary and
2071 secondary diagnoses, primary and secondary procedures, illness severity, patient age and source
2072 of payment.

2073 “Charge”, the uniform price for specific services within a revenue center of a hospital.

2074 “Child”, a person who is under 18 years of age.

2075 “Commissioner”, the commissioner of medical assistance or the secretary of elder affairs,
2076 as appropriate.

2077 “Community health centers”, health centers operating in conformance with Section 330
2078 of United States Public Law 95-626 and shall include all community health centers which file
2079 cost reports as requested by the institute.

2080 “Comprehensive cancer center”, the hospital of any institution so designated by the
2081 national cancer institute under the authority of 42 USC sections 408(a) and 408(b) organized
2082 solely for the treatment of cancer, and offered exemption from the Medicare diagnosis related
2083 group payment system under 42 C.F.R. 405.475(f).

2084 “Department”, the department of elder affairs.

2085 “Disproportionate share hospital”, an acute hospital that exhibits a payer mix where a
2086 minimum of 63 per cent of the acute hospital’s gross patient service revenue is attributable to
2087 Title XVIII and Title XIX of the federal Social Security Act other government payers and free
2088 care.

2089 “Division”, the division of medical assistance within the executive office of health and
2090 human services; but for the purposes of sections 9 to 52, inclusive, a reference to the word
2091 “division” shall mean the department of elder affairs, whenever appropriate.

2092 “Emergency medical condition”, a medical condition, whether physical or mental,
2093 manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of
2094 prompt medical attention could reasonably be expected by a prudent layperson who possesses an
2095 average knowledge of health and medicine, to result in placing the health of the person or
2096 another person in serious jeopardy, serious impairment to body function, or serious dysfunction
2097 of any body organ or part, or, with respect to a pregnant woman, as further defined in section
2098 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

2099 “Emergency services”, medically necessary health care services provided to an individual
2100 with an emergency medical condition.

2101 “Employee”, a person who performs services primarily in the commonwealth for
2102 remuneration for a commonwealth employer; provided, that “employee” shall not include a
2103 person who is self-employed.

2104 “Employer”, an employer as defined in section 1 of chapter 151A.

2105 “Enrollee”, a person who becomes a member of an insurance program of the division
2106 either individually or as a member of a family.

2107 “Executive office”, the executive office of health and human services.

2108 “Financial requirements”, a hospital’s requirement for revenue which shall include, but
2109 not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of
2110 depreciation of plant and equipment and the reasonable costs associated with changes in medical
2111 practice and technology.

2112 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
2113 ends in the calendar year by which it is identified.

2114 “Free care”, the following medically necessary services provided to individuals
2115 determined to be financially unable to pay for their care, in whole or in part, under applicable
2116 regulations of the executive office: (1) services provided by acute hospitals; (2) services
2117 provided by community health centers; and (3) patients in situations of medical hardship in
2118 which major expenditures for health care have depleted or can reasonably be expected to deplete

2119 the financial resources of the individual to the extent that medical services cannot be paid, as
2120 determined by regulations of the executive office.

2121 “General health supplies, care or rehabilitative services and accommodations”, all
2122 supplies, care and services of medical, optometric, dental, surgical, podiatric, psychiatric,
2123 therapeutic, diagnostic, rehabilitative, supportive or geriatric nature, including inpatient and
2124 outpatient hospital care and services, and accommodations in hospitals, sanatoria, infirmaries,
2125 convalescent and nursing homes, retirement homes, facilities established, licensed or approved
2126 under chapter 111B and providing services of a medical or health-related nature, and similar
2127 institutions including those providing treatment, training, instruction and care of children and
2128 adults; provided, however, that rehabilitative service shall include only rehabilitative services of
2129 a medical or health-related nature which are eligible for reimbursement under Title XIX of the
2130 Social Security Act.

2131 “Governmental mandate”, a state or federal statutory requirement, administrative rule,
2132 regulation, assessment, executive order, judicial order or other governmental requirement that
2133 directly or indirectly imposes an obligation and associated compliance cost upon a provider to
2134 take an action or to refrain from taking an action in order to fulfill the provider’s contractual duty
2135 to a procuring governmental unit.

2136 “Governmental unit”, the commonwealth, any department, agency board or commission
2137 of the commonwealth and any political subdivision of the commonwealth.

2138 “Gross patient service revenue”, the total dollar amount of a hospital’s charges for
2139 services rendered in a fiscal year.

2140 “Health care services”, supplies, care and services of medical, surgical, optometric,
2141 dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative,
2142 supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital
2143 care and services; services provided by a community health center or by a sanatorium, as
2144 included in the definition of “hospital” in Title XVIII of the federal Social Security Act, and
2145 treatment and care compatible with such services or by a health maintenance organization.

2146 “Health insurance company”, a company as defined in section 1 of chapter 175 which
2147 engages in the business of health insurance.

2148 “Health insurance plan”, the Medicare program or an individual or group contract or
2149 other plan providing coverage of health care services and which is issued by a health insurance
2150 company, a hospital service corporation, a medical service corporation or a health maintenance
2151 organization.

2152 “Health maintenance organization”, a company which provides or arranges for the
2153 provision of health care services to enrolled members in exchange primarily for a prepaid per
2154 capita or aggregate fixed sum as further defined in section 1 of chapter 176G.

2155 “Hospital”, a hospital licensed under section 51 of chapter 111, the teaching hospital of
2156 the University of Massachusetts Medical School and any psychiatric facility licensed under
2157 section 19 of chapter 19.

2158 “Institution”, a licensed hospital, nursing home or public medical institution that meets
2159 the requirements of the secretary.

2160 “Medicaid”, the jointly funded state and federal medical assistance program established
2161 under Title XIX under section 9 of this chapter.

2162 “Medical assistance”, payment by the department, or its agent, or any predecessor or
2163 successor agency, of all or part of the cost of the medical care and services provided to recipients
2164 of any program established under this chapter, but not including benefits provided under section
2165 9A.

2166 “Medical assistance program”, the Medicaid program, the Veterans Administration health
2167 and hospital programs and any other medical assistance program operated by a governmental
2168 unit for persons categorically eligible for such program.

2169 “Medically necessary services”, medically necessary inpatient and outpatient services as
2170 mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall
2171 not include: (1) non-medical services, such as social, educational and vocational services; (2)
2172 cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and
2173 consultations; (5) court testimony; (6) research or the provision of experimental or unproven
2174 procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-
2175 surgery hormone therapy; and (7) the provision of whole blood; and provided, however, that
2176 administrative and processing costs associated with the provision of blood and its derivatives
2177 shall be payable.

2178 “Medical benefits”, benefits provided under section 9A.

2179 “Medicare program”, the medical insurance program established by Title XVIII of the
2180 Social Security Act.

2181 “Non-acute hospital”, a hospital which is not an acute hospital.

2182 “Patient”, a natural person receiving health care services from a hospital.

2183 “Pediatric hospital”, an acute care hospital which limits services primarily to children and
2184 which qualifies as exempt from the Medicare Prospective Payment system regulations.

2185 “Pediatric specialty unit”, a pediatric unit of an acute care hospital in which the ratio of
2186 licensed pediatric beds to total licensed hospital beds as of July 1, 1994, exceeded 0.20. In
2187 calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds,
2188 and the total of all licensed hospital beds shall include the total of all licensed acute care hospital
2189 beds, consistent with Medicare’s acute care hospital reimbursement methodology as put forth in
2190 the Provider Reimbursement Manual Part 1, Section 2405.3G.

2191 “Person”, an individual who resides in the commonwealth or any individual residing
2192 outside the commonwealth who is deemed to be a resident of the commonwealth under Title
2193 XIX.

2194 “Provider”, an institution, agency, individual or other legal entity qualified under the laws
2195 of the commonwealth to perform the medical care or services for which medical assistance and
2196 medical benefits are available under this chapter.

2197 “Public medical institution”, a medical institution supported in whole or in part by public
2198 funds, either federal, state or municipal staffed by professional, medical and nursing personnel
2199 and providing medical care, in accordance with standards established through licensing or
2200 approval by the department of public health.

2201 “Publicly aided patient”, a person who receives hospital care and services for which a
2202 governmental unit is liable, in whole or in part, under a statutory program of public assistance.

2203 “Purchaser”, a natural person responsible for payment for health care services rendered
2204 by a hospital.

2205 “Reside”, to occupy an established place of abode with no present intention of definite
2206 and early removal, but not necessarily with the intention of remaining permanently, but in no
2207 event shall the word “reside” be construed more restrictively or less restrictively than as defined
2208 by the Secretary under Title XIX.

2209 “Resident”, a person living in the commonwealth, as defined by the executive office by
2210 regulation; provided, however, that such regulation shall not define a resident as a person who
2211 moved into the commonwealth for the sole purpose of securing health insurance under this
2212 chapter; and provided, further that confinement of a person in a nursing home, hospital or other
2213 medical institution shall not in and of itself, suffice to qualify such person as a resident.

2214 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
2215 patient for a charge.

2216 “Secretary”, the Secretary of the United States Department of Health and Human
2217 Services, except as that term is used in section 2 of this chapter.

2218 “Self-employed”, a person who, at common law, is not considered to be an employee and
2219 whose primary source of income is derived from the pursuit of a bona fide business.

2220 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
2221 business, which is not a health insurance plan, and in which the business is liable for the actual
2222 costs of the health care services provided by the plan and administrative costs.

2223 “Social service program”, a social, mental health, developmental disabilities, habilitative,
2224 rehabilitative, substance abuse, residential care, adult or adolescent day care, vocational,
2225 employment and training or elder service program or accommodations, purchased by a
2226 governmental unit or political subdivision of the executive office of health and human services,
2227 but excluding any program, service or accommodation that: (a) is reimbursable under a Medicaid
2228 waiver granted under section 1115 of Title XI of the Social Security Act; or (b) is funded
2229 exclusively by a federal grant.

2230 “Social service program provider”, a provider of social service programs in the
2231 commonwealth.

2232 “Sole community provider”, any acute hospital which qualifies as a sole community
2233 provider under Medicare regulations or under regulations promulgated by the executive office,
2234 which regulations shall consider factors including, but not limited to, isolated location, weather
2235 conditions, travel conditions, percentage of Medicare, Medicaid and free care provided and the
2236 absence of other reasonably accessible hospitals in the area; provided, that such hospitals shall
2237 include those which are located more than 25 miles from other such hospitals in the
2238 commonwealth and which provide services for at least 60 per cent of their primary service area.

2239 “Specialty hospital”, an acute hospital which qualifies for an exemption from the
2240 Medicare prospective payment system regulations or an acute hospital which limits its

2241 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to
2242 children or patients under obstetrical care.

2243 “State institution”, a hospital, sanatorium, infirmary, clinic and other such facility owned,
2244 operated or administered by the commonwealth, which furnishes general health supplies, care or
2245 rehabilitative services and accommodations.

2246 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX
2247 programs, other governmental payers, insurance companies, health maintenance organizations
2248 and nonprofit hospital service corporations; provided, however, that “third party payer” shall not
2249 include a purchaser responsible for payment for health care services rendered by a hospital,
2250 either to the purchaser or to the hospital.

2251 “Title XIX”, Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq. or any
2252 successor thereto.

2253 “Title XXI”, Title XXI of the Social Security Act, 42 USC 1397 et seq. or any successor
2254 thereto.

2255 SECTION 91. Section 9C of said chapter 118E, as so appearing, is hereby amended by
2256 striking out, in line 145, the words “established by subsection (c) of section 18 of chapter 118G”.

2257 SECTION 92. Section 12 of said chapter 118E, as so appearing, is hereby amended by
2258 striking out, in line 11, the word “division” and inserting in place thereof the following word:-
2259 institute.

2260 SECTION 93. Section 13 of said chapter 118E, as so appearing, is hereby amended by
2261 striking out, in lines 3 and 4, the words “division of health care finance and policy established by

2262 chapter one hundred and eighteen G, which shall be called the “division” only” and inserting in
2263 place thereof the following words:- executive office of health and human services, which shall be
2264 called the “executive office” only or by a governmental unit designated by the executive office.

2265 SECTION 94. Said section 13 of said chapter 118E, as so appearing, is hereby further
2266 amended by striking out, in lines, 9, 15, 18, 20, 22, and 23 the word “division” and inserting in
2267 place thereof, in each instance, the following words:- executive office.

2268 SECTION 95. Said section 13 of said chapter 118E, as so appearing, is hereby further
2269 amended by striking out, in line 25, the word “division” and inserting in place thereof the
2270 following words:- institute of health care finance and policy.

2271 SECTION 96. Section 13B of said chapter 118E, as so appearing, is hereby further
2272 amended by striking out, in lines 11 and 12, the words “the Massachusetts health care quality and
2273 cost council, established under section 16K of chapter 6A and”.

2274 SECTION 97. Said chapter 118E is hereby amended by inserting after section 13B the
2275 following 10 sections:-

2276 Section 13C. The secretary of the executive office shall establish rates of payment for
2277 health care services; provided, that the secretary may designate another governmental unit to
2278 perform such ratemaking functions. The secretary of the executive office shall have the
2279 responsibility for establishing rates to be paid to providers for health care services by
2280 governmental units, including the division of industrial accidents. The rates shall be adequate to
2281 meet the costs incurred by efficiently and economically operated facilities providing care and
2282 services in conformity with applicable state and federal laws and regulations and quality and
2283 safety standards and which are within the financial capacity of the commonwealth.

2284 Notwithstanding any general or special law or rule or regulation to the contrary, the secretary of
2285 the executive office shall have the responsibility for establishing fair and adequate charges to be
2286 used by state institutions for general health supplies, care and rehabilitative services and
2287 accommodations, which charges shall be based on the actual costs of the state institution
2288 reasonably related, in the circumstances of each institution, to the efficient production of the
2289 services in the institution and shall also have sole responsibility for determining rates paid for
2290 educational assessments conducted or performed by psychologists and trained, certified
2291 educational personnel under the tenth paragraph of section 3 of chapter 71B.

2292 The secretary of the executive office shall have the sole responsibility for establishing
2293 rates of payment for social service programs which are reasonable and adequate to meet the costs
2294 which are incurred by efficiently and economically operated social service program providers in
2295 providing social service programs in conformity with federal and state law, regulations and
2296 quality and safety standards. When establishing rates of payment for social service programs, the
2297 secretary of the executive office shall adjust rates to take into account factors, including, but not
2298 limited to: (a) the reasonable cost to social service program providers of any existing or new
2299 governmental mandate that has been enacted, promulgated or imposed by any governmental unit
2300 or federal governmental authority; (b) a cost adjustment factor to reflect changes in reasonable
2301 costs of goods and services of social service programs including those attributed to inflation; and
2302 (c) geographic differences in wages, benefits, housing and real estate costs in each metropolitan
2303 statistical area of the commonwealth, and in any city or town therein where such costs are
2304 substantially higher than the average cost within that area as a whole. The secretary of the
2305 executive office shall not consider any of the resources specified in section 13G when
2306 establishing, reviewing or approving rates of payment for social service programs.

2307 Section 13D. The executive office, or a governmental unit designated to perform
2308 ratemaking functions by the executive office, (1) shall determine, after public hearing, at least
2309 annually for institutional providers, and at least biennially for non-institutional providers, the
2310 rates to be paid by each governmental unit to providers of health care services and social service
2311 programs; provided, however, that for the purposes of this section, social service program
2312 providers shall be treated as non-institutional providers; (2) shall determine, after public hearing,
2313 at least annually, the rates to be charged by each state institution for general health supplies, care
2314 or rehabilitative services and accommodations; (3) shall certify to each affected governmental
2315 unit the rates so determined; (4) shall determine, after public hearing, at least annually, and
2316 certify to the division of industrial accidents of the department of labor and industries, rates of
2317 payment for general health supplies, care or rehabilitative services and accommodations, which
2318 rates shall be paid for services under chapter 152; (5) shall, upon request of the division of
2319 insurance, assist the division of insurance in the performance of its duties as set forth in section 4
2320 of chapter 176B; and (6) may establish fair and reasonable classifications upon which any rates
2321 may be based for rest homes, nursing homes and convalescent homes; provided, however, that
2322 the executive office shall not cause a decrease in a rate or add a penalty to a rate because such
2323 home has an equity position which is less than 0.

2324 Such rates for nursing homes and rest homes, as defined under section 71 of chapter 11,
2325 shall be established as of October 1 of each year. In setting such rates, the executive office shall
2326 use as base year costs for rate determination purposes the reported costs of the calendar year not
2327 more than 4 years prior to the current rate year, adjusted for reasonableness and to incorporate
2328 any audit findings applicable to said base year costs. In any appeal of rates under section 13E,
2329 the petitioner shall not be permitted to introduce into the records of such an appeal evidence of

2330 costs for any year other than the base year used to establish the rate. Notwithstanding any other
2331 general or special law or regulation to the contrary, except as provided in this chapter, each
2332 governmental unit shall pay to a provider of services and each state institution shall charge as a
2333 provider of health care services, as the case may be, the rates for general health supplies, care
2334 and rehabilitative services and accommodations determined and certified by the executive office.
2335 In establishing rates of payment to providers of services, the executive office shall control rate
2336 increases and shall impose such methods and standards as are necessary to ensure reimbursement
2337 for those costs which must be incurred by efficiently and economically operated facilities and
2338 providers. Such methods and standards may include, but shall not be limited to, the following:
2339 peer group cost analyses; ceilings on capital and operating costs; productivity standards; caps or
2340 other limitations on the utilization of temporary nursing or other personnel services; use of
2341 national or regional indices to measure increases or decreases in reasonable costs; limits on
2342 administrative costs associated with the use of management companies; the availability of
2343 discounts for large volume purchasers; the revision of existing historical cost bases, where
2344 applicable, to reflect norms or models of efficient service delivery; and other means to encourage
2345 the cost-efficient delivery of services. Rates produced using these methods and standards shall be
2346 in conformance with Title XIX, including the upper limit on provider payments.

2347 In determining rates to be paid by governmental units to providers of services, the
2348 executive office shall include as an operating expense of a provider of services any contribution
2349 made in lieu of taxes by such provider of services to a city or town and shall establish by
2350 regulation those expenses treated as business deductions under the Internal Revenue Code, which
2351 shall be included as allowable operating expenses in determining rates of reimbursement. Except
2352 for ceilings or maximum rates of reimbursement, which are determined in accordance with rate

2353 determination methods imposed on nursing homes, any ceiling or maximum imposed by the
2354 executive office upon the rate of reimbursement to be paid to rest homes shall reflect the actual
2355 costs of rest home providers and shall not prevent any such rest home provider from receiving
2356 full payment for costs necessarily incurred in the provision of services in compliance with
2357 federal or state regulations and requirements.

2358 In determining rates to be paid by governmental units to acute-care hospitals, as defined
2359 in section 25B of chapter 111, and any hospital or separate unit of a hospital that provides acute
2360 psychiatric services, as defined in said section 25B, the executive office shall include as an
2361 operating expense the reasonable cost of providing competent interpreter services as required by
2362 section 25J of said chapter 111 or section 23A of chapter 123.

2363 No hospital shall receive reimbursement or payment from any governmental unit for
2364 amounts paid to employees, as salary, or to consultant or other firms, as fees, where the primary
2365 responsibility of the employees or consultants is, either directly or indirectly, to persuade or seek
2366 to persuade the employees of the hospital to support or oppose unionization. Attorney's fees for
2367 services rendered in dealing directly with a union, in advising hospital management of its
2368 responsibilities under the National Labor Relations Act, or for services at an administrative
2369 agency or court or for services by an attorney in preparation for the agency or in court
2370 proceeding shall not be support or opposition to unionization.

2371 The executive office shall establish rates on a prospective basis, subject to rules and
2372 regulations promulgated by the executive office.

2373 In establishing rates for nursing pools under section 72Y of chapter 111, the executive
2374 office shall establish annually the limit for the rate for service provided by nursing pools to

2375 licensed facilities. The executive office shall establish industry-wide class rates for such services
2376 and shall establish separate class rates for services provided to nursing facilities and hospitals.
2377 The executive office shall establish separate rates for registered nurses, licensed practical nurses
2378 and certified nursing assistants. The executive office may establish rates by geographic region.
2379 The rates shall include an allowance for wages, payroll taxes and fringe benefits, which shall be
2380 based upon, and shall not exceed, median wages, payroll taxes and fringe benefits paid to
2381 permanent medical personnel of the same type at health care facilities in the same geographic
2382 region. The rates shall also include an allowance for reasonable administrative expenses and a
2383 reasonable profit factor, as determined by the executive office. The executive office may exempt
2384 from the rates certain categories, as defined by the executive office, of fixed-term employees that
2385 work exclusively at a particular health care facility for a period of at least 90 days and for whose
2386 services there is a contract between a facility and a nursing pool registered with the department
2387 of public health. The executive office shall establish procedures by which nursing pools shall
2388 submit cost reports, which may be subject to audit, to the executive office to establish rates. The
2389 executive office shall determine the nursing pool rate contained in this paragraph by considering
2390 wage and benefit data collected from cost reports received from nursing pools and from health
2391 care facilities and other relevant information gathered through other collection tools or
2392 reasonable methodologies.

2393 Except as otherwise provided in this section any person aggrieved by any rate
2394 determination made under this section shall have a right of appeal as provided under section 13E.

2395 The executive office may enter into such contracts or agreements with the federal
2396 government, a political subdivision of the commonwealth or any public or private corporation or
2397 organization, as it deems necessary; provided, however, that the executive office shall not enter

2398 into any contract or agreement with a private corporation or organization to furnish information
2399 and statistical data to be used by said executive office as its sole basis for setting rates, if such
2400 private corporation or organization is to make or receive payments based upon the rates so set.

2401 Each governmental unit shall cooperate with the executive office at all times in the
2402 furtherance of the executive office's purposes. Each state institution shall permit the executive
2403 office or any designated representatives of the executive office, to examine its books and
2404 accounts and shall file with the executive office from time to time or upon request such data,
2405 statistics, schedules or other information as the executive office may reasonably require.

2406 Each rate established by the executive office shall be a regulation and shall be subject to
2407 review as hereinafter provided. The executive office shall promulgate rules and regulations for
2408 the administration of its duties and the determination of rates as are herein required subject to the
2409 procedures prescribed by chapter 30A. Every rate, classification and other regulation established
2410 by the executive office shall be consistent where applicable with the principles of reimbursement
2411 for provider costs in effect from time to time under Titles XVIII and XIX of the Social Security
2412 Act governing reimbursements or grants available to the commonwealth, its departments,
2413 agencies, boards, divisions or political subdivisions for general health supplies, care and
2414 rehabilitative services and accommodations.

2415 In the event that any aggregate rates certified by the executive office exceed the upper
2416 limit of payment in effect for any period under Titles XVIII or Title XIX of the Social Security
2417 Act or any other requirement of said Titles, where applicable, the executive office shall re-
2418 determine and recertify any such aggregate rates in order to bring them into compliance with
2419 such federal requirement for the entire period during which such upper limit is effective.

2420 This section shall not apply to acute or non-acute hospitals; provided, however, that this
2421 section shall apply to acute and non-acute hospitals for services under the workers'
2422 compensation act.

2423 Section 13E. Except for rates established under section 13F, any person, corporation or
2424 other party aggrieved by an interim rate or a final rate established by the executive office or a
2425 governmental unit designated to perform ratemaking functions by the executive office, or by
2426 failure of the executive office to set a rate or to take other action required by law and desiring a
2427 review thereof shall, within 30 days after said rate is filed with the state secretary or may, at any
2428 time, if there is a failure to determine a rate or take any action required by law, file an appeal
2429 with the division of administrative law appeals established by section 4H of chapter 7. Any
2430 appeal filed under this section shall be accompanied by a certified statement that said appeal is
2431 not interposed for delay. On appeal, the rate determined for any provider of services shall be
2432 adequate, fair and reasonable for such provider, based upon, the costs of such provider, but not
2433 limited thereto.

2434 On an appeal from an interim rate or a final rate the division of administrative law
2435 appeals shall conduct an adjudicatory proceeding under chapter 30A, and said division shall file
2436 its decision with the secretary of the executive office and the state secretary within 30 days after
2437 the conclusion of the hearing.

2438 Said decision shall contain a statement of the reasons for such decision, including a
2439 determination of each issue of fact or law upon which such decision was based. If such decision
2440 results in a recommendation for a rate different from that certified, the executive office shall
2441 establish a new rate based upon such statement of reasons. If the secretary of the executive office

2442 determines that the statement of reasons is inadequate to determine a fair, reasonable and
2443 adequate rate, it may remand the appeal to the hearing officer for further investigation. Any party
2444 aggrieved by a decision of the division may, within 30 days of the receipt of such decision, file a
2445 petition for review in superior court for the county of Suffolk, which shall have exclusive
2446 jurisdiction of such review.

2447 A provider may appeal as an aggrieved party under the preceding sentence, in the event
2448 that a remand by the executive office to a hearing officer does not result in a final decision by the
2449 executive office within 21 days of the date of remand.

2450 The petition shall set forth the grounds upon which the decision of the division should be
2451 set aside. The aggrieved party shall, within 7 days after the petition for review is filed, notify the
2452 executive office and all the parties to the appeal before said division that a petition for review has
2453 been filed by sending each a copy thereof. Within 40 days after the petition for review is filed, or
2454 within such further time as the court may allow, the division of administrative law appeals shall
2455 file in court the original or a certified copy of the record under review. The court may affirm,
2456 modify or set aside the decision of the executive office in whole or in part, remand the decision
2457 to the executive office for further proceedings or enter such other order as justice may require.
2458 Nothing in this section shall be construed to prevent the division from granting temporary relief
2459 if, in its discretion, such relief is justified nor, from informally adjusting or settling controversies
2460 with the consent of all parties.

2461 Judicial review shall be governed by section 14 of chapter 30A to the extent not
2462 inconsistent with this section.

2463 Section 13E ½. All purchasers and third party payers, excluding purchasers and payers
2464 under the workers' compensation act, except as provided in chapter 152, may enter into
2465 contractual arrangements with acute and non-acute hospitals for services. No such arrangement,
2466 including but not limited to, prices or charges which may be charged for non-contracted services
2467 or which may be negotiated in individual contracts between such purchasers or third party payers
2468 and such acute or non-acute hospitals, shall be subject to prior approval by any public agency;
2469 provided, however, that nothing in this chapter shall limit the authority of the executive office to
2470 establish rates of payment for all health care services adjudged compensable under chapter 152,
2471 and provided, further, that charges established by an acute or non-acute hospital for health care
2472 services rendered shall be uniform for all patients receiving comparable services.

2473 Any acute or non-acute hospital that makes a charge or accepts payment based upon a
2474 charge in excess of that filed, required or approved by the executive office or that fails to file any
2475 data, statistics or schedules or other information required under this chapter or by any regulation
2476 promulgated by the executive office or which falsifies the same, shall be subject to a civil
2477 penalty of not more than \$1,000 for each day on which such violation occurs or continues, which
2478 penalty may be assessed in an action brought on behalf of the commonwealth in any court of
2479 competent jurisdiction. The attorney general shall bring any appropriate action, including
2480 injunctive relief, as may be necessary for the enforcement of this chapter.

2481 Section 13F. All rates of payment to acute hospitals and non-acute hospitals under Title
2482 XIX shall be established by contract between the provider of such hospital services and the
2483 office of Medicaid, except as provided in subsections (a) and (b), or otherwise permitted by law.
2484 All rates shall be subject to all applicable Title XIX statutory and regulatory requirements and

2485 shall include reimbursement for the reasonable cost of providing competent interpreter services
2486 under section 25J of chapter 111 or section 23A of chapter 123.

2487 All such rates for non-acute hospitals shall be effective as of the date specified in section
2488 13A, unless otherwise specified by law.

2489 (a) For disproportionate share hospitals, the executive office shall establish rates that
2490 equal the financial requirements of providing care to recipients of medical assistance.

2491 (b) The executive office, or governmental unit designated by the executive office, shall
2492 establish rates of payment which shall apply to emergency services and continuing emergency
2493 care provided in acute hospitals to medical assistance program recipients, including examination
2494 or treatment for an emergency medical condition or active labor in women or any other care
2495 rendered to the extent required by 42 USC 1395(dd), unless such services are provided under an
2496 agreement between the office of Medicaid and the acute hospital. Such rates of payment shall
2497 reflect the reasonable costs of providing such care, including the costs of providing competent
2498 interpreter services under section 25J of chapter 111 or section 23A of chapter 123 and shall take
2499 into account the characteristics of the hospital in which such care is provided, including, but not
2500 limited to, its status as a teaching hospital, specialty hospital, disproportionate share hospital,
2501 pediatric hospital, pediatric specialty unit or sole community provider. An acute hospital shall,
2502 when a medical assistance program recipient requires post emergency room care and, after
2503 screening and stabilizing the patient's condition, notify the office of Medicaid or its designated
2504 representative and assist said office, to the extent possible, in transferring the recipient to an
2505 appropriate medical setting under said office's direction. Nothing in this section shall be
2506 construed to require the hospital to breach its obligation under said 42 USC 1395(dd) or require

2507 the recipient to forego any right to refuse transfer under said 42 USC 1395(dd). If an acute
2508 hospital is unable or prohibited by law or regulation from transferring the patient under said
2509 office's direction, said executive office shall pay for any and all care associated with such
2510 patient's treatment including, but not limited to, care or services provided in the emergency room
2511 or in an inpatient or outpatient setting. Whenever said office is required to pay for such care
2512 rendered in a non-emergency room setting, said office shall pay all reasonable costs for such
2513 services in such hospital, as determined by the executive office under this chapter and consistent
2514 with Title XIX laws.

2515 No acute hospital may charge to a governmental unit for services provided to publicly
2516 aided patients at a rate higher than the rate payable by the office of Medicaid under Title XIX for
2517 the same service, unless such service is provided by said office under a unique arrangement such
2518 as a selective contract or a managed care contract.

2519 Nothing in this chapter shall be construed to conflict with a waiver of otherwise
2520 applicable federal requirements which the office of Medicaid may obtain from the secretary of
2521 health and human services to implement a primary care case management system for delivering
2522 services, or to implement any other type of managed care service delivery system in which the
2523 eligible recipient is directed to obtain services exclusively from 1 provider or 1 group of
2524 providers.

2525 If the office of Medicaid contracts with any third party payer for the provision of medical
2526 benefits for medical assistance recipients under Title XIX, said office shall assure that on a
2527 quarterly basis such contracted third party payers notify each acute hospital of the number of
2528 inpatient days of service provided by the hospital to such recipients covered by such contracts.

2529 (c) The executive office, or a governmental unit designated to perform ratemaking
2530 functions by the executive office, shall establish rates of payment which shall apply to
2531 community hospitals located in rural and isolated areas where access to other such providers is
2532 not reasonably available. Such hospitals, specially designated by the commonwealth as sole
2533 community providers, shall receive payment rates calculated to reflect the rural characteristics of
2534 such community hospital and the essential nature of the services they provide, which rates shall
2535 not be less than 97 per cent of such hospitals' reasonable financial requirements.

2536 Section 13G. The executive office, or a governmental unit designated to perform
2537 ratemaking functions by the executive office, shall not consider the following as resources of
2538 such hospitals in the establishment, review or approval of acute and non-acute hospital rates and
2539 charges: restricted and unrestricted grants; gifts; contributions; bequests; fund principle; term
2540 endowments and endowment balances; restricted gifts; unrestricted gifts and all income from any
2541 of the foregoing, including unrestricted income from endowment funds and income and gains
2542 from investment of unrestricted funds. The following words shall have the following meanings
2543 as used in this paragraph:

2544 "Income and gains from investment of unrestricted funds", interest, dividends, rents or
2545 other income on investments, including net gains or losses resulting from investment
2546 transactions.

2547 "Term endowment", funds available upon termination of restrictions.

2548 "Unrestricted gifts", gifts, grants, contributions and bequests, upon which there are no
2549 restrictions imposed by the donor.

2550 “Unrestricted income from endowment funds”, income earned on investment of
2551 endowment funds which have no restrictions on income.

2552 An acute or non-acute care hospital aggrieved by any action or failure to act by the
2553 executive office under this chapter may file an appeal under section 13E.

2554 Section 13H. No acute hospital shall deny access to care and services which the hospital
2555 would provide under this chapter to recipients of benefits under chapter 117A.

2556 Section 13I. Notwithstanding any provisions of this chapter to the contrary, all costs and
2557 charges for patients who are residents of other countries shall, as provided herein, be exempted
2558 from the limitations imposed by this chapter. Any hospital shall be allowed to impose a
2559 surcharge on the normal charges that would otherwise be allowed for such residents of other
2560 countries. Such surcharges shall not be included in the calculation of gross patient service
2561 revenues. The normal charge and the patient discharge statistics shall otherwise be included
2562 under this chapter.

2563 Section 13J. A health maintenance organization organized under chapter 176G may (i)
2564 negotiate directly with any hospital with respect to such health maintenance organization’s rate
2565 of payment for hospital services and (ii) enter into an agreement with such hospital reflecting
2566 such rate of payment without the approval of the executive office. The specification in this
2567 section of contracting rights of health maintenance organizations shall not be construed as
2568 affirming or denying such rights with respect to any other third party payer.

2569 Section 13K. Upon petition of a receiver appointed under section 72 N of chapter 111,
2570 the executive office shall, under regulations to be promulgated hereunder, adjust the facility’s
2571 rate, if necessary, to insure compensation of the receiver and payment for a bond. Such

2572 adjustment shall not be in effect if the licensee is under the jurisdiction of the United States
2573 Bankruptcy Court.

2574 SECTION 98. Section 14 of said chapter 118E, as appearing in the 2010 Official Edition,
2575 is hereby amended by striking out, in lines 4 and 5 and 66, the words “division of health care
2576 finance and policy” and inserting in place thereof, in each instance, the following words:-
2577 executive office of health and human services or a governmental unit designated by the executive
2578 office.

2579 SECTION 99. Subsection (e) of section 22 of said chapter 118E, as so appearing, is
2580 hereby amended by striking out, in lines 46 and 47, the words “36 of chapter 118G” and
2581 inserting in place thereof the following figure:- 69.

2582 SECTION 100. Subsection (k) of said section 22 of said chapter 118E, as so appearing, is
2583 hereby amended by striking out, in lines 93 and 96, the word “118G” and inserting in place
2584 thereof, in each instance, the following word:- 118E.

2585 SECTION 101. Said section 22 of said chapter 118E, as so appearing, is hereby amended
2586 by striking out, in lines 44 and 45, 65, 71, 86 and 87 and 110, the words “division of health care
2587 finance and policy” and inserting in place thereof, in each instance, the following words:-
2588 executive office of health and human services.

2589 SECTION 102. Subsection (m) of said section 22 of said chapter 118E, as so appearing,
2590 is hereby amended by striking out, in lines 112 and 113, the words “39 of chapter 118G” and
2591 inserting in place thereof the following figure:- 69.

2592 SECTION 103. Section 23 of said chapter 118E, as so appearing, is hereby amended by
2593 striking out, in line 74, the words “39 of chapter 118G” and inserting in place thereof the
2594 following figure:- 69.

2595 SECTION 104. Said chapter 118E is hereby further amended by inserting after section 62
2596 the following 13 sections:-

2597 Section 63. (a) For the purposes of this section, the following words shall have the
2598 following meanings:—

2599 “Assessment”, the user fee imposed under this section; provided that for all nursing
2600 homes, the user fee shall be imposed per non Medicare reimbursed patient day; provided, further
2601 that a Medicare-reimbursed patient day shall be a Medicare Part A patient day paid for under
2602 either an indemnity fee-for-service arrangement or a Medicare health maintenance organization
2603 contract.

2604 “Nursing home”, a nursing home or a distinct part of a nursing unit of a hospital or other
2605 facility licensed by the department of public health under section 71 of chapter 111.

2606 “Patient day”, a day of care provided to an individual patient by a nursing home.

2607 (b) Each nursing home shall pay an assessment per non-Medicare reimbursed patient day.
2608 The assessment shall be sufficient in the aggregate to generate \$145 million in each fiscal year.
2609 The assessment shall be implemented as a broad based health care-related fee as defined in 42
2610 U.S.C. § 1396b(w)(3)(B). The assessment shall be paid to the executive office quarterly. The
2611 executive office may promulgate regulations that authorize the assessment of interest on any
2612 unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees at a

2613 rate not to exceed 5 per cent per month. The receipts from the assessment, any federal financial
2614 participation received by the commonwealth as a result of expenditures funded by these
2615 assessments and interest thereon shall be credited to the General Fund.

2616 (c) The secretary of the executive office shall prepare a form on which each nursing
2617 home shall report quarterly its total patient days and shall calculate the assessment due. The
2618 secretary of the executive office shall distribute the forms to each nursing home at least annually.
2619 The failure to distribute the form or the failure to receive a copy of the form shall not stay the
2620 obligation to pay the assessment by the date specified in this section. The executive office may
2621 require additional reports, including but not limited to monthly census data, as it considers
2622 necessary to monitor collections and compliance.

2623 (d) The executive office shall have the authority to inspect and copy the records of a
2624 nursing home to audit its calculation of the assessment. In the event that the executive office
2625 determines that a nursing home has either overpaid or underpaid the assessment, the executive
2626 office shall notify the nursing home of the amount due or refund the overpayment. The executive
2627 office may impose per diem penalties if a nursing home fails to produce documentation as
2628 requested by the executive office.

2629 (e) In the event that a nursing home is aggrieved by a decision of the executive office as
2630 to the amount due, the nursing home may file an appeal to the division of administrative law
2631 appeals within 60 days of the date of the notice of underpayment or the date the notice was
2632 received, whichever is later. The division of administrative law appeals shall conduct each
2633 appeal as an adjudicatory proceeding under chapter 30A and a nursing home aggrieved by a

2634 decision of the division of administrative law appeals shall be entitled to judicial review under
2635 section 14 of said chapter 30A.

2636 (f) The secretary of the executive office may enforce this section by notifying the
2637 department of public health of unpaid assessments. Within 45 days after notice to a nursing home
2638 of amounts due, the department shall revoke licensure of a nursing home that fails to remit
2639 delinquent fees.

2640 (g) The executive office, in consultation with the office of Medicaid, shall promulgate
2641 regulations necessary to implement this section.

2642 Section 64. As used in sections 64 to 69, inclusive, the following words shall, unless the
2643 context clearly requires otherwise, have the following meanings:-

2644 "Acute hospital", the teaching hospital of the University of Massachusetts medical school
2645 and any hospital licensed under section 51 of chapter 111 and which contains a majority of
2646 medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public
2647 health.

2648 "Allowable reimbursement", payment to acute hospitals and community health centers
2649 for health services provided to uninsured or underinsured patients of the commonwealth under
2650 section 69 and any further regulations promulgated by the health safety net office.

2651 "Ambulatory surgical center", a distinct entity that operates exclusively to provide
2652 surgical services to patients not requiring hospitalization and meets the requirements of the
2653 federal Health Care Financing Administration for participation in the Medicare program.

2654 "Ambulatory surgical center services", services described for purposes of the Medicare
2655 program under 42 U.S.C. 1395k(a)(2)(F)(I); provided that "ambulatory surgical center services"
2656 shall include facility services only and shall not include surgical procedures.

2657 "Bad debt", an account receivable based on services furnished to a patient which: (i) is
2658 regarded as uncollectible, following reasonable collection efforts consistent with regulations of
2659 the office, which regulations shall allow third party payers to negotiate with hospitals to collect
2660 the bad debts of its enrollees; (ii) is charged as a credit loss; (iii) is not the obligation of a
2661 governmental unit or the federal government or any agency thereof; and (iv) is not a
2662 reimbursable health care service.

2663 "Community health center", a health center operating in conformance with the
2664 requirements of Section 330 of United States Public Law 95-626, including all community health
2665 centers which file cost reports as requested by the institute of health care finance and policy.

2666 "Director", the director of the health safety net office.

2667 "DRG", a patient classification scheme known as diagnosis related grouping, which
2668 provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost
2669 incurred by the hospital.

2670 "Emergency bad debt", bad debt resulting from emergency services provided by an acute
2671 hospital to an uninsured or underinsured patient or other individual who has an emergency
2672 medical condition that is regarded as uncollectible, following reasonable collection efforts
2673 consistent with regulations of the office.

2674 "Emergency medical condition", a medical condition, whether physical or mental,
2675 manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of
2676 prompt medical attention could reasonably be expected by a prudent layperson who possesses an
2677 average knowledge of health and medicine to result in placing the health of the person or another
2678 person in serious jeopardy, serious impairment to body function or serious dysfunction of any
2679 body organ or part or, with respect to a pregnant woman, as further defined in section
2680 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. 1295dd(e)(1)(B).

2681 "Emergency services", medically necessary health care services provided to an individual
2682 with an emergency medical condition.

2683 "Financial requirements", a hospital's requirement for revenue which shall include, but
2684 not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of
2685 depreciation of plant and equipment and the reasonable costs associated with changes in medical
2686 practice and technology.

2687 "Fund", the Health Safety Net Trust Fund established under section 66.

2688 "Fund fiscal year", the 12-month period starting in October and ending in September.

2689 "Gross patient service revenue", the total dollar amount of a hospital's charges for
2690 services rendered in a fiscal year.

2691 "Health services", medically necessary inpatient and outpatient services as mandated
2692 under Title XIX of the federal Social Security Act; provided, that "health services" shall not
2693 include: (1) nonmedical services, such as social, educational and vocational services; (2)
2694 cosmetic surgery; (3) canceled or missed appointments; (4) telephone conversations and

2695 consultations; (5) court testimony; (6) research or the provision of experimental or unproven
2696 procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-
2697 surgery hormone therapy; and (7) the provision of whole blood, but the administrative and
2698 processing costs associated with the provision of blood and its derivatives shall be payable.

2699 "Managed care organization", a managed care organization, as defined in 42 CFR 438.2,
2700 and any eligible health insurance plan, as defined in section 1 of chapter 118H, that contracts
2701 with MassHealth or the commonwealth health insurance connector authority; provided, however,
2702 that "managed care organization" shall not include a senior care organization, as defined in
2703 section 9D of chapter 118E.

2704 "Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge
2705 payors to acute hospitals for health services and ambulatory surgical centers for ambulatory
2706 surgical center services; provided, however, that "payments subject to surcharge" shall not
2707 include: (i) payments, settlements and judgments arising out of third party liability claims for
2708 bodily injury which are paid under the terms of property or casualty insurance policies; (ii)
2709 payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in
2710 policies issued under chapter 176K or similar policies issued on a group basis; provided further,
2711 that "payments subject to surcharge" shall include payments made by a managed care
2712 organization on behalf of: (i) Medicaid recipients under age 65; and (ii) enrollees in the
2713 commonwealth care health insurance program; and provided further, that "payments subject to
2714 surcharge" may exclude amounts established under regulations promulgated by the division for
2715 which the costs and efficiency of billing a surcharge payor or enforcing collection of the
2716 surcharge from a surcharge payor would not be cost effective.

2717 "Pediatric hospital", an acute care hospital which limits services primarily to children and
2718 which qualifies as exempt from the Medicare Prospective Payment system regulations.

2719 "Pediatric specialty unit", a pediatric unit of an acute care hospital in which the ratio of
2720 licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20; provided
2721 that in calculating that ratio, licensed pediatric beds shall include the total of all pediatric service
2722 beds, and the total of all licensed hospital beds shall include the total of all licensed acute care
2723 hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put
2724 forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

2725 "Private sector charges", gross patient service revenue attributable to all patients less
2726 gross patient service revenue attributable to Titles XVIII and XIX, other public-aided patients,
2727 reimbursable health services and bad debt.

2728 "Reimbursable health services", health services provided to uninsured and underinsured
2729 patients who are determined to be financially unable to pay for their care, in whole or part, under
2730 applicable regulations of the office; provided that the health services are services provided by
2731 acute hospitals or services provided by community health centers; and provided further, that such
2732 services shall not be eligible for reimbursement by any other public or private third-party payer.

2733 "Resident", a person living in the commonwealth, as defined by the office by regulation;
2734 provided, however, that such regulation shall not define as a resident a person who moved into
2735 the commonwealth for the sole purpose of securing health insurance under this chapter.

2736 Confinement of a person in a nursing home, hospital or other medical institution shall not in and
2737 of itself, suffice to qualify such person as a resident.

2738 "Surcharge payor", an individual or entity that pays for or arranges for the purchase of
2739 health care services provided by acute hospitals and ambulatory surgical center services provided
2740 by ambulatory surgical centers, as defined in this section; provided, however, that the term
2741 "surcharge payor" shall include a managed care organization; and provided further, that
2742 "surcharge payor" shall not include Title XVIII and Title XIX programs and their beneficiaries or
2743 recipients, other governmental programs of public assistance and their beneficiaries or recipients
2744 and the workers' compensation program established under chapter 152.

2745 "Underinsured patient", a patient whose health insurance plan or self-insurance health
2746 plan does not pay, in whole or in part, for health services that are eligible for reimbursement
2747 from the health safety net trust fund, provided that such patient meets income eligibility
2748 standards set by the office.

2749 "Uninsured patient", a patient who is a resident of the commonwealth, who is not covered
2750 by a health insurance plan or a self-insurance health plan and who is not eligible for a medical
2751 assistance program.

2752 Section 65. (a) There shall be established within the office of Medicaid a health safety net
2753 office which shall be under the supervision and control of a director. The director shall be
2754 appointed by the secretary of the executive office and shall be a person of skill and experience in
2755 the field of health care finance and administration. The director shall be the executive and
2756 administrative head of the office and shall be responsible for administering and enforcing the law
2757 relative to the office and to each administrative unit of the office. The director shall receive such
2758 salary as may be determined by law, and shall devote full time to the duties of the office. In the
2759 case of an absence or vacancy in the office of the director, or in the case of disability as

2760 determined by the secretary of the executive office, the secretary of the executive office may
2761 designate an acting director to serve as director until the vacancy is filled or the absence or
2762 disability ceases. The acting director shall have all the powers and duties of the director and shall
2763 have similar qualifications as the director.

2764 (b) The office shall have the following powers and duties: (1) to administer the Health
2765 Safety Net Trust Fund, established under section 66, and to require payments to the fund
2766 consistent with acute hospitals' and surcharge payors' liability to the fund, as determined under
2767 sections 67 and 68, and any further regulations promulgated by the office; (2) to set in
2768 consultation with the office of Medicaid, reimbursement rates for payments from the fund to
2769 acute hospitals and community health centers for reimbursable health services provided to
2770 uninsured and underinsured patients and to disburse monies from the fund consistent with such
2771 rates; provided that the office shall implement a fee-for-service reimbursement system for acute
2772 hospitals; (3) to promulgate regulations further defining: (a) eligibility criteria for reimbursable
2773 health services; (b) the scope of health services that are eligible for reimbursement by the Health
2774 Safety Net Trust Fund; (c) standards for medical hardship; and (d) standards for reasonable
2775 efforts to collect payments for the costs of emergency care; provided that the office shall verify
2776 eligibility using the eligibility system of the office of Medicaid and other appropriate sources to
2777 determine the eligibility of uninsured and underinsured patients for reimbursable health services
2778 and shall establish other procedures to ensure that payments from the fund are made for health
2779 services for which there is no other public or private third party payer, including disallowance of
2780 payments to acute hospitals and community health centers for health services provided to
2781 individuals if reimbursement is available from other public or private sources; (4) to develop
2782 programs and guidelines to encourage maximum enrollment of uninsured individuals who

2783 receive health services reimbursed by the fund into health care plans and programs of health
2784 insurance offered by public and private sources and to promote the delivery of care in the most
2785 appropriate setting, provided that the programs and guidelines are developed in consultation with
2786 the commonwealth health insurance connector, established under chapter 176Q; and provided
2787 further that these programs shall not deny payments from the fund because services should have
2788 been provided in a more appropriate setting if the hospital was required to provide the services
2789 under 42 U.S.C. 1395 (dd); (5) to conduct a utilization review program designed to monitor the
2790 appropriateness of services for which payments were made by the fund and to promote the
2791 delivery of care in the most appropriate setting; and to administer demonstration programs that
2792 reduce health safety net trust fund liability to acute hospitals, including a demonstration program
2793 to enable disease management for patients with chronic diseases, substance abuse and psychiatric
2794 disorders through enrollment of patients in community health centers and community mental
2795 health centers and through coordination between these centers and acute hospitals, provided, that
2796 the office shall report the results of these reviews annually to the joint committee on health care
2797 financing and the house and senate committees on ways and means; (6) to enter into agreements
2798 or transactions with any federal, state or municipal agency or other public institution or with a
2799 private individual, partnership, firm, corporation, association or other entity and to make
2800 contracts and execute all instruments necessary or convenient for the carrying on of its business;
2801 (7) to secure payment, without imposing undue hardship upon any individual, for unpaid bills
2802 owed to acute hospitals by individuals for health services that are ineligible for reimbursement
2803 from the Health Safety Net Trust Fund which have been accounted for as bad debt by the
2804 hospital and which are voluntarily referred by a hospital to the department for collection;
2805 provided, however that such unpaid charges shall be considered debts owed to the

2806 commonwealth and all payments received shall be credited to the fund; and provided, further,
2807 that all actions to secure such payments shall be conducted in compliance with a protocol
2808 previously submitted by the office to the joint committee on health care financing; (8) to require
2809 hospitals and community health centers to submit to the office data that it reasonably considers
2810 necessary; (9) to make, amend and repeal rules and regulations to effectuate the efficient use of
2811 monies from the Health Safety Net Trust Fund; provided, however, that the regulations shall be
2812 promulgated only after notice and hearing and only upon consultation with the board of the
2813 commonwealth health insurance connector, representatives of the Massachusetts Hospital
2814 Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts
2815 Safety Net Hospitals and the Massachusetts League of Community Health Centers; and (10) to
2816 provide an annual report at the close of each fund fiscal year to the joint committee on health
2817 care financing and the house and senate committees on ways and means, evaluating the
2818 processes used to determine eligibility for reimbursable health services, including the Virtual
2819 Gateway. The report shall include, but not be limited to, the following: (i) an analysis of the
2820 effectiveness of these processes in enforcing eligibility requirements for publicly-funded health
2821 programs and in enrolling uninsured residents into programs of health insurance offered by
2822 public and private sources; (ii) an assessment of the impact of these processes on the level of
2823 reimbursable health services by providers; and (iii) recommendations for ongoing improvements
2824 that will enhance the performance of eligibility determination systems and reduce hospital
2825 administrative costs.

2826 Section 66. (a) There shall be established and set up on the books of the commonwealth
2827 a fund to be known as the Health Safety Net Trust Fund, in this section and in sections 67 to 69,
2828 inclusive, called the fund, which shall be administered by the office. Expenditures from the fund

2829 shall not be subject to appropriation unless otherwise required by law. The purposes of the fund
2830 shall be: (i) to maintain a health care safety net by reimbursing hospitals and community health
2831 centers for a portion of the cost of reimbursable health services provided to low-income,
2832 uninsured or underinsured residents; and (ii) to support a portion of the costs of the Medicaid
2833 program this chapter and the commonwealth care health insurance program under chapter 118H.
2834 The office shall administer the fund using such methods, policies, procedures, standards and
2835 criteria that it deems necessary for the proper and efficient operation of the fund and programs
2836 funded by it in a manner designed to distribute the fund resources as equitably as possible. The
2837 director of the health safety net office shall determine annually the estimated expenses of the
2838 office to administer the fund.

2839 (b) The fund shall consist of all amounts paid by acute hospitals and surcharge payors
2840 under sections 67 and 68; all appropriations for the purpose of payments to acute hospitals or
2841 community health centers for health services provided to uninsured and underinsured residents;
2842 any transfers from the Commonwealth Care Trust Fund, established under section 2000 of
2843 chapter 29; and all property and securities acquired by and through the use of monies belonging
2844 to the fund and all interest thereon. Amounts placed in the fund shall, except for amounts
2845 transferred to the Commonwealth Care Trust Fund, be expended by the office for payments to
2846 hospitals and community health centers for reimbursable health services provided to uninsured
2847 and underinsured residents of the commonwealth, consistent with the requirements of this
2848 section and section 69 and the regulations promulgated by the office; provided, however, that
2849 expenses of the health safety net office under subsection (a) shall be expended annually from the
2850 fund; and provided further, that not more than \$6,000,000 shall be expended annually from the
2851 fund for demonstration projects that use case management and other methods to reduce the

2852 liability of the fund to acute hospitals; and provided further, that any amounts collected from
2853 surcharge payors in any year in excess of \$160,000,000, adjusted to reflect applicable surcharge
2854 credits, shall be transferred to the General Fund to support a portion of the costs of the Medicaid
2855 and commonwealth care health insurance programs. Any annual balance remaining in the fund
2856 after these payments have been made shall be transferred to the Commonwealth Care Trust
2857 Fund. All interest earned on the amounts in the fund shall be deposited or retained in the fund.
2858 The director shall from time to time requisition from the fund amounts that the director considers
2859 necessary to meet the current obligations of the office for the purposes of the fund and estimated
2860 obligations for a reasonable future period.

2861 Section 67. (a) An acute hospital's liability to the fund shall equal the product of (1) the
2862 ratio of its private sector charges to all acute hospitals' private sector charges; and (2)
2863 \$160,000,000. Annually, before October 1, the office shall establish each acute hospital's
2864 liability to the fund using the best data available, as determined by the health safety net office
2865 and shall update each acute hospital's liability to the fund as updated information becomes
2866 available. The office shall specify by regulation an appropriate mechanism for interim
2867 determination and payment of an acute hospital's liability to the fund. An acute hospital's
2868 liability to the fund shall in the case of a transfer of ownership be assumed by the successor in
2869 interest to the acute hospital.

2870 (b) The office shall establish by regulation an appropriate mechanism for enforcing an
2871 acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled
2872 payment to the fund. These enforcement mechanisms may include (1) an offset by the office of
2873 Medicaid of payments on the Title XIX claims of any such acute hospital or any health care
2874 provider under common ownership with the acute care hospital or any successor in interest to the

2875 acute hospital, and (2) the withholding by the office of Medicaid of the amount of payment owed
2876 to the fund, including any interest and late fees and the transfer of the withheld funds into the
2877 fund. If the office of Medicaid offsets claims payments as ordered by the office, it shall not be
2878 considered to be in breach of contract or any other obligation for the payment of non-contracted
2879 services and providers whose payment is offset under an order of the division shall serve all Title
2880 XIX recipients under the contract then in effect with the office of Medicaid, or, in the case of a
2881 non-contracting or disproportionate share hospital, under its obligation for providing services to
2882 Title XIX recipients under this chapter. In no event shall the office direct the office of Medicaid
2883 to offset claims unless an acute hospital has maintained an outstanding obligation to the fund for
2884 a period longer than 45 days and has received proper notice that the office of Medicaid intends to
2885 initiate enforcement actions under regulations promulgated by the office.

2886 Section 68. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge
2887 on all payments subject to surcharge as defined in section 64. The surcharge shall be distinct
2888 from any other amount paid by a surcharge payor for the services of an acute hospital or
2889 ambulatory surgical center. The surcharge amount shall equal the product of (i) the surcharge
2890 percentage and (ii) amounts paid for these services by a surcharge payor. The office shall
2891 calculate the surcharge percentage by dividing \$160,000,000 by the projected annual aggregate
2892 payments subject to the surcharge, excluding projected annual aggregate payments based on
2893 payments made by managed care organizations. The office shall determine the surcharge
2894 percentage before the start of each fund fiscal year and may re-determine the surcharge
2895 percentage before April 1 of each fund fiscal year if the office projects that the initial surcharge
2896 percentage established the previous October will produce less than \$150,000,000 or more than
2897 \$170,000,000 in surcharge payments, excluding payments made by managed care organizations.

2898 Before each succeeding October 1, the office shall re-determine the surcharge percentage
2899 incorporating any adjustments from earlier years. In each determination or redetermination of the
2900 surcharge percentage, the office shall use the best data available as determined by the office of
2901 Medicaid and may consider the effect on projected surcharge payments of any modified or
2902 waived enforcement under subsection (e). The office shall incorporate all adjustments, including,
2903 but not limited to, updates or corrections or final settlement amounts, by prospective adjustment
2904 rather than by retrospective payments or assessments.

2905 (b) Each acute hospital and ambulatory surgical center shall bill a surcharge payor an
2906 amount equal to the surcharge described in subsection (a) as a separate and identifiable amount
2907 distinct from any amount paid by a surcharge payor for acute hospital or ambulatory surgical
2908 center services. Each surcharge payor shall pay the surcharge amount to the office for deposit in
2909 the Health Safety Net Trust Fund on behalf of said acute hospital or ambulatory surgical center.
2910 Upon the written request of a surcharge payor, the office may implement another billing or
2911 collection method for the surcharge payor; provided, however, that the office has received all
2912 information that it requests which is necessary to implement such billing or collection method;
2913 and provided further, that the office shall specify by regulation the criteria for reviewing and
2914 approving such requests and the elements of such alternative method or methods.

2915 (c) The office shall specify by regulation appropriate mechanisms that provide for
2916 determination and payment of a surcharge payor's liability, including requirements for data to be
2917 submitted by surcharge payors, acute hospitals and ambulatory surgical centers.

2918 (d) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
2919 assumed by the successor in interest to the surcharge payor.

2920 (e) The office shall establish by regulation an appropriate mechanism for enforcing a
2921 surcharge payor's liability to the fund if a surcharge payor does not make a scheduled payment to
2922 the fund; provided, however, that the office may, for the purpose of administrative simplicity,
2923 establish threshold liability amounts below which enforcement may be modified or waived. Such
2924 enforcement mechanism may include assessment of interest on the unpaid liability at a rate not to
2925 exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5
2926 per cent per month. Such enforcement mechanism may also include notification to the office of
2927 Medicaid requiring an offset of payments on the claims of the surcharge payor, any entity under
2928 common ownership or any successor in interest to the surcharge payor, from the office of
2929 Medicaid in the amount of payment owed to the fund including any interest and penalties, and to
2930 transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as
2931 ordered by the office, the office of Medicaid shall be considered not to be in breach of contract
2932 or any other obligation for payment of non-contracted services, and a surcharge payor whose
2933 payment is offset under an order of the office shall serve all Title XIX recipients under the
2934 contract then in effect with the executive office of health and human services. In no event shall
2935 the office direct the office of Medicaid to offset claims unless the surcharge payor has
2936 maintained an outstanding liability to the fund for a period longer than 45 days and has received
2937 proper notice that the office intends to initiate enforcement actions under regulations
2938 promulgated by the office.

2939 (f) If a surcharge payor fails to file any data, statistics or schedules or other information
2940 required under this chapter or by any regulation promulgated by the office, the office shall
2941 provide written notice to the payor. If a surcharge payor fails to provide required information
2942 within 14 days after the receipt of written notice, or falsifies the same, the surcharge payor shall

2943 be subject to a civil penalty of not more than \$5,000 for each day on which the violation occurs
2944 or continues, which penalty may be assessed in an action brought on behalf of the
2945 commonwealth in any court of competent jurisdiction. The attorney general shall bring any
2946 appropriate action, including injunctive relief, necessary for the enforcement of this chapter.

2947 Section 69. (a) Reimbursements from the fund to hospitals and community health centers
2948 for health services provided to uninsured and underinsured individuals shall be subject to further
2949 rules and regulations promulgated by the office and shall be made in the following manner:-

2950 (1) Reimbursements made to acute hospitals shall be based on actual claims for
2951 health services provided to uninsured and underinsured patients that are submitted to the office,
2952 and shall be made only after determination that the claim is eligible for reimbursement under this
2953 chapter and any additional regulations promulgated by the office. Reimbursements for health
2954 services provided to residents of other states and foreign countries shall be prohibited and the
2955 office shall make payments to acute hospitals using fee-for-service rates calculated as provided
2956 in paragraphs (5) and (6).

2957 (2) The office shall, in consultation with the office of Medicaid, develop and
2958 implement procedures to verify the eligibility of individuals for whom health services are billed
2959 to the fund and to ensure that other coverage options are used fully before services are billed to
2960 the fund, including procedures adopted under section 66. The office may recover from a third
2961 party that is financially responsible for the costs attributable to services provided to an individual
2962 that were paid by the fund. A payment from the fund for such services shall be recoverable from
2963 the third party and the payment shall, after notice to the third party, operate as a lien under
2964 section 22 . The office shall review all claims billed to the fund to determine whether the patient

2965 is eligible for medical assistance under this chapter and whether any third party is financially
2966 responsible for the costs of care provided to the patient. In making these determinations, the
2967 office shall verify the insurance status of each individual for whom a claim is made using all
2968 sources of data available to the office. The office shall refuse to allow payments or shall disallow
2969 payments to acute hospitals and community health centers for free care provided to individuals if
2970 reimbursement is available from other public or private sources; provided, that payments shall
2971 not be denied from the fund because services should have been provided in a more appropriate
2972 setting if the hospital was required to provide these services under 42 U.S.C. 1395(dd).

2973 (3) The office shall require acute hospitals and community health centers to
2974 screen each applicant for reimbursed care for other sources of coverage and for potential
2975 eligibility for government programs and to document the results of that screening. If an acute
2976 hospital or community health center determines that an applicant is potentially eligible for
2977 Medicaid or for the commonwealth care health insurance program, established under chapter
2978 118H, or another assistance program, the acute hospital or community health center shall assist
2979 the applicant in applying for benefits under that program. The office shall audit the accounts of
2980 acute hospitals and community health centers to determine compliance with this section and shall
2981 deny payments from the fund for any acute hospital or community health center that fails to
2982 document compliance with this section.

2983 (4) Notwithstanding any general or special law to the contrary, an applicant for
2984 health safety net assistance shall, if eligible, be enrolled in MassHealth under section 9A or in the
2985 insurance reimbursement program, as provided in section 9C. An applicant deemed ineligible
2986 for either program and who is unable to make all or part of the payment for health services shall
2987 provide the name and address of the applicant's employer, if any, and the applicant's name,

2988 address, social security number and date of birth. The director of labor, in collaboration with the
2989 office, shall collaborate with the division of insurance and the department of revenue to
2990 implement this section and section 17 of chapter 176Q.

2991 (5) To pay community health centers for health services provided to uninsured
2992 individuals under this section, the office shall pay community health centers a base rate that shall
2993 be no less than the then-current Medicare Federally Qualified Health Center rate as required
2994 under 42 U.S.C. 13951 (a)(3), and the office shall add payments for additional services not
2995 included in the base rate, including, but not limited to, EPSDT services, 340B pharmacy, urgent
2996 care, and emergency room diversion services.

2997 (6) Reimbursements to acute hospitals and community health centers for bad debt
2998 shall be made upon submission of evidence, in a form to be determined by the office, that
2999 reasonable efforts to collect the debt have been made.

3000 (7) The office shall reimburse acute hospitals for health services provided to
3001 individuals based on the payment systems in effect for acute hospitals used by the United States
3002 Department of Health and Human Services Centers for Medicare & Medicaid Services to
3003 administer the Medicare Program under Title XVIII of the Social Security Act, including all of
3004 Medicare's adjustments for direct and indirect graduate medical education, disproportionate
3005 share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of
3006 the annual increase in the Medicare hospital market basket index. The office shall, in
3007 consultation with the office of Medicaid and the Massachusetts Hospital Association, promulgate
3008 regulations necessary to modify these payment systems to account for: (i) the differences
3009 between the program administered by the office and the Title XVIII Medicare program,

3010 including the services and benefits covered; (ii) grouper and DRG relative weights for purposes
3011 of calculating the payment rates to reimburse acute hospitals at rates no less than the rates they
3012 are reimbursed by Medicare; (iii) the extent and duration of covered services; (iv) the
3013 populations served; and (v) any other adjustments to the payment methodology under this section
3014 as considered necessary by the office, based upon circumstances of individual hospitals.

3015 Following implementation of this section, the office shall ensure that the allowable
3016 reimbursement rates under this section for health services provided to uninsured individuals shall
3017 not thereafter be less than rates of payment for comparable services under the Medicare program,
3018 taking into account the adjustments required by this section.

3019 (b) By April 1 of the year preceding the start of the fund fiscal year, the office shall, after
3020 consultation with the office of Medicaid, and using the best data available, provide an estimate of
3021 the projected total reimbursable health services provided by acute hospitals and community
3022 health centers and emergency bad debt costs, the total funding available and any projected
3023 shortfall after adjusting for reimbursement payments to community health centers. If a shortfall
3024 in revenue exists in any fund fiscal year to cover projected costs for reimbursement of health
3025 services, the office shall allocate that shortfall in a manner that reflects each hospital's
3026 proportional financial requirement for reimbursements from the fund, including, but not limited
3027 to, the establishment of a graduated reimbursement system and under any additional regulations
3028 promulgated by the office.

3029 (c) The executive office of health and human services shall enter into interagency
3030 agreements with the department of revenue to verify income data for patients whose health care
3031 services are reimbursed by the Health Safety Net Trust Fund and to recover payments made by

3032 the fund for services provided to individuals who are ineligible to receive reimbursable health
3033 services or on whose behalf the fund has paid for emergency bad debt. The office shall
3034 promulgate regulations requiring acute hospitals to submit data that will enable the department of
3035 revenue to pursue recoveries from individuals who are ineligible for reimbursable health services
3036 and on whose behalf the fund has made payments to acute hospitals for such services or
3037 emergency bad debt. Any amounts recovered, including amounts received under chapter 62D,
3038 shall be deposited in the Health Safety Net Trust Fund, established in section 66.

3039 (d) The office shall not at any time make payments from the fund for any period in excess
3040 of amounts that have been paid into or are available in the fund for that period, but the office
3041 may temporarily prorate payments from the fund for cash flow purposes.

3042 Section 70. (a) Acute hospitals and ambulatory surgical centers shall assess a health
3043 system benefit surcharge on all payments subject to surcharge in addition to the surcharge
3044 assessed under section 68. The health system benefit surcharge shall be distinct from any other
3045 amount paid by a surcharge payor for the services of an acute hospital or ambulatory surgical
3046 center. The health system benefit surcharge amount shall equal the product of (i) the health
3047 system benefit surcharge percentage and (ii) amounts paid for these services by a surcharge
3048 payor. The office shall calculate the health system benefit surcharge percentage by dividing
3049 \$40,000,000 by the projected annual aggregate payments subject to the health system benefit
3050 surcharge, excluding projected annual aggregate payments based on payments made by managed
3051 care organizations. The office shall determine the health system benefit surcharge percentage
3052 before the start of each fund fiscal year and may re-determine the health system benefit
3053 surcharge percentage before April 1 of each fund fiscal year if the office projects that the initial
3054 health system benefit surcharge percentage established the previous October will produce less

3055 than \$30,000,000 or more than \$50,000,000 in health system benefit surcharge payments,
3056 excluding payments made by managed care organizations. Before each succeeding October 1,
3057 the office shall re-determine the health system benefit surcharge percentage incorporating any
3058 adjustments from earlier years. In each determination or redetermination of the health system
3059 benefit surcharge percentage, the office shall use the best data available as determined by the
3060 office of Medicaid and may consider the effect on projected health system benefit surcharge
3061 payments of any modified or waived enforcement under subsection (e). The office shall
3062 incorporate all adjustments, including, but not limited to, updates or corrections or final
3063 settlement amounts, by prospective adjustment rather than by retrospective payments or
3064 assessments.

3065 (b) One half of all health system benefit surcharge payments shall be deposited in the
3066 Prevention and Wellness Trust Fund, established in section 2G of chapter 111. One half of all
3067 health system benefit surcharge payments shall be deposited in the e-Health Institute Fund,
3068 established in section 6E of chapter 40J.

3069 (c) Each acute hospital and ambulatory surgical center shall bill a health system benefit
3070 surcharge payor an amount equal to the health system benefit surcharge described in subsection
3071 (a) as a separate and identifiable amount distinct from any amount paid by a surcharge payor for
3072 acute hospital or ambulatory surgical center services. Each health system benefit surcharge payor
3073 shall pay the health system benefit surcharge amount to the office for deposit in the Prevention
3074 and Wellness Trust Fund and the e-Health Institute Fund on behalf of said acute hospital or
3075 ambulatory surgical center. Upon the written request of a health system benefit surcharge payor,
3076 the office may implement another billing or collection method for the health system benefit
3077 surcharge payor; provided, however, that the office has received all information that it requests

3078 which is necessary to implement such billing or collection method; and provided further, that the
3079 office shall specify by regulation the criteria for reviewing and approving such requests and the
3080 elements of such alternative method or methods.

3081 (d) The office shall specify by regulation appropriate mechanisms that provide for
3082 determination and payment of a health system benefit surcharge payor's liability, including
3083 requirements for data to be submitted by health system benefit surcharge payors, acute hospitals
3084 and ambulatory surgical centers.

3085 (e) A health system benefit surcharge payor's liability to the fund shall in the case of a
3086 transfer of ownership be assumed by the successor in interest to the health system benefit
3087 surcharge payor.

3088 (f) The office shall establish by regulation an appropriate mechanism for enforcing a
3089 health system benefit surcharge payor's liability to the fund if a health system benefit surcharge
3090 payor does not make a scheduled payment to the funds; provided, however, that the office may,
3091 for the purpose of administrative simplicity, establish threshold liability amounts below which
3092 enforcement may be modified or waived. Such enforcement mechanism may include assessment
3093 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent
3094 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement
3095 mechanism may also include notification to the office of Medicaid requiring an offset of
3096 payments on the claims of the health system benefit surcharge payor, any entity under common
3097 ownership or any successor in interest to the health system benefit surcharge payor, from the
3098 office of Medicaid in the amount of payment owed to the fund including any interest and
3099 penalties and to transfer the withheld funds into said fund. If the office of Medicaid offsets

3100 claims payments as ordered by the office, the office of Medicaid shall be considered not to be in
3101 breach of contract or any other obligation for payment of non-contracted services and a health
3102 system benefit surcharge payor whose payment is offset under an order of the office shall serve
3103 all Title XIX recipients under the contract then in effect with the executive office of health and
3104 human services. In no event shall the office direct the office of Medicaid to offset claims unless
3105 the health system benefit surcharge payor has maintained an outstanding liability to the fund for
3106 longer than 45 days and has received proper notice that the office intends to initiate enforcement
3107 actions under regulations promulgated by the office.

3108 (g) If a health system benefit surcharge payor fails to file any data, statistics or schedules
3109 or other information required under this chapter or by any regulation promulgated by the office,
3110 the office shall provide written notice to the payor. If a health system benefit surcharge payor
3111 fails to provide required information within 14 days after the receipt of written notice, or falsifies
3112 the same, the payor shall be subject to a civil penalty of not more than \$5,000 for each day on
3113 which the violation occurs or continues, which penalty may be assessed in an action brought on
3114 behalf of the commonwealth in any court of competent jurisdiction. The attorney general shall
3115 bring any appropriate action, including injunctive relief, necessary for the enforcement of this
3116 chapter.

3117 Section 71. As used in sections 71 to 76 inclusive, the following words shall, unless the
3118 context requires otherwise, have the following meanings:—

3119 “Consumer,” a person to whom a personal care attendant provides personal care services.

3120 “PCA quality home care workforce council”, “workforce council” or “the council”, the

3121 Personal Care Attendant quality home care workforce council established under section 72.

3122 “Personal care attendant,” a person, including a personal aide, who has been selected by a
3123 consumer or the consumer’s surrogate to provide personal care services to persons with
3124 disabilities or seniors under the MassHealth personal care attendant program or any successor
3125 program.

3126 “Surrogate” means the consumer’s legal guardian or person identified in a written
3127 agreement with the consumer as responsible for hiring, directing and firing on behalf of the
3128 consumer.

3129 Section 72. (a) The PCA quality home care workforce council is established in the
3130 executive office of health and human services but shall not be subject to the control thereof to
3131 ensure the quality of long-term, in-home, personal care by recruiting, training and stabilizing the
3132 work force of personal care attendants.

3133 (b) The PCA quality home care workforce council shall consist of 9 members appointed
3134 under this section. At all times, a majority of the members of the council shall be consumers as
3135 defined in this chapter. In making appointments to the council, the governor shall appoint the
3136 secretary of the executive office of health and human services or a designee, who shall serve as
3137 chair, the secretary of labor and workforce development or a designee and 1 member from a slate
3138 of 3 consumers recommended by the governor's special advisory commission on disability
3139 policy. The auditor shall appoint 1 member from a slate of 3 consumers recommended by the
3140 developmental disabilities council, 1 member from a slate of 3 consumers recommended by the
3141 Massachusetts office on disability, and 1 member from a slate of 3 consumers recommended by
3142 the statewide independent living council. The attorney general shall appoint 1 member from a
3143 slate of 3 consumers or consumer surrogates recommended by the Massachusetts home care

3144 association, 1 member from a slate of 3 consumers or consumer surrogates recommended by the
3145 Massachusetts council on aging and 1 member chosen at the attorney general's discretion. The
3146 secretary of the executive office of health and human services or a designee and the secretary of
3147 labor and workforce development or a designee shall be permanent members during their term in
3148 office. Appointees to the council shall serve 3-year terms. If a vacancy occurs, the executive
3149 officer who made the original appointment shall appoint a new council member to serve the
3150 remainder of the unexpired term or, in the event that the vacancy occurs as the result of the
3151 completion of a term, to serve a full term, and such appointment shall become immediately
3152 effective upon the member taking the appropriate oath. If the departing council member was
3153 appointed under a recommendation made under this paragraph, the executive officer shall make
3154 the new appointment from a slate of 3 recommendations put forth by the entity that originally
3155 recommended the departing council member. Members of the council may serve for successive
3156 terms of office. A majority of the council shall constitute a quorum for the transaction of any
3157 business. Members of the council shall not receive compensation for their council service but
3158 members shall be reimbursed for their actual expenses necessarily incurred in the performance of
3159 their duties.

3160 Section 73. (a) The workforce council shall carry out the following duties:

3161 (1) Undertake recruiting efforts to identify and recruit prospective personal care
3162 attendants;

3163 (2) Provide training opportunities, either directly or through contract, for personal
3164 care attendants and consumers;

3165 (3) Provide assistance to consumers and consumer surrogates in finding personal
3166 care attendants by establishing a referral directory of personal care attendants; provided that
3167 before placing a personal care attendant on the referral directory, the workforce council shall
3168 determine that the personal care attendant has met the requirements established by the executive
3169 office in its applicable regulations and has not stated in writing a desire to be excluded from the
3170 directory;

3171 (4) Provide routine, emergency and respite referrals of personal care attendants to
3172 consumers and consumer surrogates who are authorized to receive long-term, in-home personal
3173 care services through a personal care attendant;

3174 (5) Give preference in the recruiting, training, referral and employment of
3175 personal care attendants to recipients of public assistance or other low-income persons who
3176 would qualify for public assistance in the absence of such employment; and

3177 (6) Cooperate with state and local agencies on health and aging and other federal,
3178 state and local agencies to provide the services described and set forth in this section. If, in the
3179 course of carrying out its duties, the PCA quality home care workforce council identifies
3180 concerns regarding the services being provided by a personal care attendant, the workforce
3181 council shall notify the relevant office.

3182 (b) In determining how best to carry out its duties, the PCA quality home care workforce
3183 council shall identify existing personal care attendant recruitment, training and referral resources
3184 made available to consumers or the consumer's surrogate by other state and local public, private
3185 and nonprofit agencies. The council may coordinate with the agencies to provide a local presence
3186 for the council and to provide consumers or the consumer's surrogate greater access to personal

3187 care attendant recruitment, training and referral resources in a cost-effective manner. Using
3188 requests for proposals or similar processes, the council may contract with the agencies to provide
3189 recruitment, training and referral. The council shall provide an opportunity for consumer
3190 participation in coordination efforts.

3191 (c) The commonwealth shall provide to the council a list of all personal care attendants
3192 who have been paid through the MassHealth personal care attendant program and shall update
3193 the list not less frequently than every 6 months to ensure that the council has a complete and
3194 accurate list at all times.

3195 Section 74. (a) Consumers or the consumer's surrogate shall retain the right to select,
3196 hire, schedule, train, direct, supervise and terminate any personal care attendant providing
3197 services to them. Consumers or the consumer's surrogate may elect to receive long-term, in-
3198 home personal care services from personal care attendants who are not referred to them by the
3199 council.

3200 (b) Personal care attendants shall be considered public employees, as defined by and
3201 solely for the purposes of, chapter 150E and section 17J of chapter 180. Said chapter 150E shall
3202 apply to personal care attendants except to the extent that chapter 150E is inconsistent with this
3203 section, in which case this section shall control. In addition, personal care attendants shall be
3204 treated as state employees solely for the purposes of sections 17A and 17G of chapter 180.
3205 Personal care attendants shall not be considered public employees or state employees for any
3206 purpose other than those set forth in this paragraph. The PCA quality home care workforce
3207 council shall be the employer, as defined by and solely for the purposes of said chapter 150E and
3208 said sections 17A, 17G and 17J of said chapter 180 and deductions under said sections 17A, 17G

3209 and 17J may be made by any entity authorized by the commonwealth to compensate personal
3210 care attendants through the MassHealth personal care attendant program. Personal care
3211 attendants shall not be eligible for benefits through the group insurance commission, the state
3212 board of retirement or the state employee workers' compensation program.

3213 (c) Personal care attendants who are employees of the council under this section shall not
3214 be considered, for that reason, public employees or employees of the council for any other
3215 purpose. Nothing in this chapter shall alter the obligations of the commonwealth or the consumer
3216 to provide their share of social security, federal and state unemployment taxes, Medicare and
3217 worker's compensation insurance under the Federal Insurance Contributions Act, federal and
3218 state unemployment law or the Massachusetts Workers' Compensation Act.

3219 (d) Consistent with section 9A of chapter 150E, no personal care attendant shall engage
3220 in a strike and no personal care attendant shall induce, encourage or condone any strike, work
3221 stoppage, slowdown or withholding of services by any personal care attendant.

3222 (e) The only bargaining unit appropriate for the purpose of collective bargaining shall be
3223 a statewide unit of all personal care attendants. The showing of interest required to request an
3224 election is 10 per cent of the bargaining unit. An intervener seeking to appear on the ballot must
3225 make the same showing of interest.

3226 (f) The council or its contractors, may not be held vicariously liable for the action or
3227 inaction of any personal care attendant, whether or not that personal care attendant was included
3228 on the council's referral directory or referred to a consumer or the consumer's surrogate.

3229 (g) The members of the council shall be immune from any liability resulting from
3230 implementation of sections 71 to 76, inclusive.

3231 Section 75. (a) The PCA quality home care workforce council may make and execute
3232 contracts and all other instruments necessary or convenient for the performance of its duties or
3233 exercise of its powers, including contracts with public and private agencies, organizations,
3234 corporations and individuals to pay them for services rendered or furnished.

3235 (b) The council may offer and provide recruitment, training and referral services to
3236 personal care attendants and consumers of long-term in-home personal care services other than
3237 statutorily defined personal care attendants and consumers, for a fee to be determined by the
3238 council.

3239 (c) The council may issue rules or regulations, as necessary, for the purpose and policies
3240 of sections 71 to 76, inclusive.

3241 (d) Subject to appropriation, the chairperson of the council with the council's approval
3242 may establish offices, employ and discharge employees, agents and contractors as necessary, and
3243 prescribe their duties and powers and fix their compensation, incur expenses, and create such
3244 liabilities as are reasonable and proper for the administration of sections 71 to 76, inclusive.

3245 (e) The council may solicit and accept for use any grant of money, services or property
3246 from the federal government, the state or any political subdivision or agency thereof, including
3247 federal matching funds under Title XIX of the Federal Social Security Act, and do all things
3248 necessary to cooperate with the federal government, the state, or any political subdivision or
3249 agency thereof, in making an application for any grant.

3250 (f) The council may coordinate its activities and cooperate with similar agencies in other
3251 states.

3252 (g) The council may establish technical advisory committees to assist the council.

3253 (h) The council may keep records and engage in research and the gathering of relevant
3254 statistics.

3255 (i) The council may acquire, hold or dispose of real or personal property, or any interest
3256 therein, and construct, lease or otherwise provide facilities for the activities conducted under
3257 sections 71 to 76, inclusive, but the workforce council may not exercise any power of eminent
3258 domain.

3259 (j) The council may delegate to the appropriate persons the power to execute contracts
3260 and other instruments on its behalf and delegate any of its powers and duties, if consistent with
3261 sections 71 to 76, inclusive.

3262 (k) The council may perform other acts necessary or convenient to execute the powers
3263 expressly granted to it.

3264 Section 76. (a) The council shall conduct a performance review every 2 years, submit a
3265 report of the review to the legislature and the governor and make the report available to the
3266 public upon submission to the governor and the legislature.

3267 (b) The performance review and report shall include an evaluation of the health, welfare
3268 and satisfaction with services provided of the consumers receiving long-term in-home personal
3269 care services from personal care attendants under sections 71 to 76, inclusive, including the
3270 degree to which all required services have been delivered, the degree to which consumers
3271 receiving services from personal care attendants have ultimately required additional or more
3272 intensive services, such as home health care, or have been placed in other residential settings or

3273 nursing homes, the promptness of response to consumer complaints and any other issue
3274 considered to be relevant.

3275 (c) The performance review report shall provide an explanation of the full cost of
3276 personal care services, including the administrative costs of the council, unemployment
3277 compensation, Social Security and Medicare payroll taxes paid and any oversight costs.

3278 (d) The performance review report shall make recommendations to the legislature and the
3279 governor for any amendments to sections 71 to 76, inclusive to further ensure the well-being of
3280 consumers, and the most efficient means of delivering required services.

3281 SECTION 105. Chapter 118G of the General Laws is hereby repealed.

3282 SECTION 106. Section 14 of chapter 122 of the General Laws, as appearing in the 2010
3283 Official Edition, is hereby amended by striking out, in lines 17 and 18, the words “division of
3284 health care finance and policy” and inserting in place thereof the following words:- executive
3285 office of health and human services or a governmental unit designated by the executive office.

3286 SECTION 107. Section 32 of chapter 123 of the General Laws, as so appearing, is hereby
3287 amended by striking out, in lines 4 and 5, the words “division of health care finance and policy”
3288 and inserting in place thereof the following words:- executive office of health and human
3289 services or a governmental unit designated by the executive office.

3290 SECTION 108. Section 33 of said chapter 123, as so appearing, is hereby amended by
3291 striking out, in lines 20 and 25, the words “division of health care finance and policy” and
3292 inserting in place thereof, in each instance, the following words:- executive office of health and
3293 human services or a governmental unit designated by the executive office.

3294 SECTION 109. Section 16 of chapter 123B of the General Laws, as so appearing, is
3295 hereby amended by striking out, in lines 4 and 5, the words “division of health care finance and
3296 policy” and inserting in place thereof the following words:- executive office of health and human
3297 services or a governmental unit designated by the executive office.

3298 SECTION 110. Chapter 149 of the General Laws is hereby amended by striking out
3299 section 6D ½, as so appearing, and inserting in place thereof the following section:-

3300 Section 6D ½. No employee shall be penalized by an employer as a result of such
3301 employee’s filing of an application to the Health Safety Net Trust Fund or otherwise providing
3302 notice to the executive office of health and human services or to a health care provider in regard
3303 to the need for health care services for that employee that results in the employer being required
3304 to reimburse the fund in whole or in part.

3305 SECTION 111. Subsection (a) of section 188 of said chapter 149, as so appearing, is
3306 hereby amended by striking out the definition of “commissioner” and inserting in place thereof
3307 the following definition:- “Connector”, the commonwealth health insurance connector
3308 established by chapter 176Q.

3309 SECTION 112. Said subsection (a) of said section 188 of said chapter 149, as so
3310 appearing, is hereby further amended by striking out the definition of “division”.

3311 SECTION 113. Subsection (c) of said section 188 of said chapter 149, as amended by
3312 section 134 of chapter 3 of the acts of 2011, is hereby further amended by striking out, in line 29,
3313 the words “commissioner of health care finance and policy”, , and inserting in place thereof the
3314 following word:- connector.

3315 SECTION 114. Said subsection (c) of said section 188 of said chapter 149, as so
3316 amended, is hereby further amended by striking out, in lines 42, 57, 60, 69 and 70 the word
3317 “division” and inserting in place thereof, in each instance, the following word:- connector.

3318 SECTION 115. Said section 188 of said chapter 149, as appearing in the 2010 Official
3319 Edition, is hereby amended by striking out, in lines 37 and 38, and in line 41, the words
3320 “uncompensated care pool, or any successor thereto” and inserting in place thereof, in each
3321 instance, the following words:- health safety net.

3322 SECTION 116. Section 1 of chapter 150E of the General Laws, as amended by section
3323 23 of chapter 93 of the acts of 2011, is hereby amended by striking out the words “28 of chapter
3324 118G” and inserting in place thereof the following words:- 70 of chapter 118E.

3325 SECTION 117. Said section 1 of said chapter 150E of the General Laws, as so amended,
3326 is hereby further amended by striking out the words “29 of chapter 118G” and inserting in place
3327 thereof the following words:- 71 of chapter 118E.

3328 SECTION 118. Subsection (c) of section 46 of chapter 151A of the General Laws, as
3329 appearing in the 2010 Official Edition, is hereby amended by striking out clause (7) and inserting
3330 in place thereof the following 2 clauses:-

3331 (7) to the commonwealth health insurance connector, information under an interagency
3332 agreement for the administration and enforcement of sections 17 and 18 of chapter 176Q and for
3333 the administration of the fair share employer contribution requirement under section 188 of
3334 chapter 149.

3335 (7 ½) to the executive office of health and human services, information under an
3336 interagency agreement for the administration and enforcement of paragraph (4) of subsection (a)
3337 of section 69 of chapter 118E.

3338 SECTION 119. Section 13 of chapter 152 of the General Laws, as so appearing, is hereby
3339 amended by striking out, in lines 3 and 4, the words “division of health care finance and policy
3340 under the provisions of chapter one hundred and eighteen G” and inserting in place thereof the
3341 following words:- executive office of health and human services under chapter 118E or a
3342 governmental unit designated by the executive office.

3343 SECTION 120. Said section 13 of said chapter 152, as so appearing, is hereby further
3344 amended by striking out, in lines 9, 10, 16 and 21, the word “division” and inserting in place
3345 thereof, in each instance, the following words:- executive office.

3346 SECTION 121. Said section 13 of said chapter 152, as so appearing, is hereby further
3347 amended by striking out, in lines 22 and 23, the words “one hundred and eighteen G” and
3348 inserting in place thereof the following word:- 118E.

3349 SECTION 122. Said section 13 of said chapter 152, as so appearing, is hereby further
3350 amended by striking out, in line 37, the words “one hundred and eighteen G” and inserting in
3351 place thereof the following word:- 118E.

3352 SECTION 123. Section 5 of chapter 176A of the General Laws, as so appearing, is
3353 hereby amended by striking out, in lines 34 and 35, the words “division of health care finance
3354 and policy, in this section called the division” and inserting in place thereof the following
3355 words:- executive office of health and human services, in this section called the executive office,
3356 or a governmental unit designated by the executive office.

3357 SECTION 124. Section 17 of said chapter 176A, as so appearing, is hereby amended by
3358 striking out, in lines 4 and 10, the word “division” and inserting in place thereof, in each
3359 instance, the following word:- institute.

3360 SECTION 125. Subsection (d) of section 6 of chapter 176J of the General Laws, as so
3361 appearing, is hereby amended by striking out, in lines 61 to 64, inclusive the words “, with the
3362 exception of any carrier whose Risk Based Capital Ratio falls below 300% for the most recent
3363 four consecutive quarters. For such carriers the reported contribution to surplus may not exceed
3364 2.5 per cent”, and inserting in place thereof the following words:-

3365 ; provided, however, that for any carrier whose Risk Based Capital Ratio falls below 300
3366 per cent for the most recent 4 consecutive quarters, the reported contribution to surplus may not
3367 exceed 2.5 per cent; provided further, that for any carrier whose Risk Based Capital Ratio is
3368 greater than 600 per cent for the most recent 4 consecutive quarters, the reported contribution to
3369 surplus shall not exceed 0.5 per cent; and provided further, that for any carrier whose Risk Based
3370 Capital Ratio is greater than 700 per cent for the 4 most recent 4 consecutive quarters, the
3371 reported contribution to surplus shall not exceed 0 per cent.

3372 SECTION 126. The second sentence of the second paragraph of subsection (a) of section
3373 11 of chapter 176J of the General Laws, as so appearing, is hereby amended by striking out, in
3374 lines 70 and 74, the words “6 of chapter 118G” and inserting in place thereof, in each instance,
3375 the following words:- 10 of chapter 12C.

3376 SECTION 127. Section 12 of said chapter 176J, as so appearing, is hereby amended by
3377 striking out, in line 59, the word “division” and inserting in place thereof the following word:-
3378 institute.

3379 SECTION 128. Said section 12 of said chapter 176J, as so appearing, is hereby further
3380 amended by adding the following subsection:-

3381 (h) Any rates offered by a carrier to a certified group purchasing cooperative under this
3382 section shall be based on those group base premium rates that apply to individuals and small
3383 employer groups enrolling outside the group purchasing cooperative but may differ based on:

3384 (1) a benefit rate adjustment factor that would apply to the certified group
3385 purchasing cooperative product if its covered benefits are different than those that apply outside
3386 the certified group purchasing cooperative;

3387 (2) a cooperative adjustment factor that would reflect the relative difference in
3388 the projected experience of the members projected to be enrolled in health benefit plans through
3389 the certified group purchasing cooperative relative to the projected experience of the members
3390 projected to be enrolled in health benefit plans outside the certified group purchasing
3391 cooperative; or

3392 (3) any other rate adjustment factor resulting in a discount of up to 10 per cent.
3393 Any adjustment greater than 10 per cent shall require prior approval in writing from the
3394 commissioner.

3395 SECTION 129. Subsection (e) of section 5 of chapter 176M of the General Laws, as so
3396 appearing, is hereby amended by striking out, in lines 94 to 96, the words “division of health care
3397 finance and policy established under chapter one hundred and eighteen G” and inserting in place
3398 thereof the following words:- institute of health care finance and policy established under chapter
3399 12C.

3400 SECTION 130. Said subsection (e) of said section 5 of said chapter 176M, as so
3401 appearing, is hereby further amended by striking out, in line 99, the word “division” and
3402 inserting in place thereof the following word:- institute.

3403 SECTION 131. Section 1 of chapter 176O of the General Laws, as so appearing, is
3404 hereby amended by inserting after the definition of “Adverse determination” the following
3405 definition:-

3406 “Allowed amount,” the contractually agreed upon amount paid by a carrier to a health
3407 care provider for health care services provided to an insured.

3408 SECTION 132. Said section 1 of said chapter 176O, as so appearing, is hereby further
3409 amended by striking out the definition of “Incentive plan” and inserting in place thereof the
3410 following definition:-

3411 “Incentive plan,” any compensation arrangement between a carrier and licensed health
3412 care professional or registered provider organization or organization that employs or utilizes
3413 services of 1 or more licensed health care professionals that may directly or indirectly have the
3414 effect of reducing or limiting services furnished to insureds of the organization.

3415 SECTION 133. Said section 1 of said chapter 176O, as so appearing, is hereby further
3416 amended by striking out the definition of “Licensed health care provider group”.

3417 SECTION 134. Said section 1 of said chapter 176O, as so appearing, is hereby further
3418 amended by inserting after the definition of “Prospective review” the following 2 definitions:-

3419 “Provider organization,” any corporation, partnership, business trust, association or
3420 organized group of persons whether incorporated or not that consists of or represents 1 or more

3421 providers in contracting with carriers for the payments the provider or providers receive for the
3422 provision of health care services; provided, that “provider organization” shall include, but not be
3423 limited to, physician organizations, physician-hospital organizations, independent practice
3424 associations, provider networks, accountable care organizations and any other organization that
3425 contracts with carriers for payment for health care services.

3426 “Registered provider organization” a provider organization that has been registered under
3427 chapter 12C.

3428 SECTION 135. Section 2 of chapter 176O of the General Laws, as so appearing, is
3429 hereby amended by striking out, in line 22, the word “division” and inserting in place thereof the
3430 following word:- institute.

3431 SECTION 136. Section 5B of said chapter 176O, as so appearing, is hereby amended by
3432 striking out, in lines 11 and 12, the words “the division of health care finance and policy, the
3433 health care quality and cost council” and inserting in place thereof the following words:- the
3434 institute of health care finance and policy.

3435 SECTION 137. Subsection (a) of section 6 of said chapter 176O, as so appearing, is
3436 hereby amended by striking out clauses (3) and (4) and inserting in place thereof the following 2
3437 clauses:-

3438 (3) the limitations on the scope of health care services and any other benefits to be
3439 provided, including: (i) all restrictions relating to preexisting condition exclusions; (ii) an
3440 explanation of any facility fee, allowed amount, co-insurance, copayment, deductible or other
3441 amount that the insured may be responsible to pay to obtain covered benefits from network or
3442 out-of-network providers; and (iii) a toll-free telephone number and website established by the

3443 carrier that enables consumers to request and obtain from a carrier within 2 working days the
3444 amount the insured will be responsible to pay for a proposed admission, procedure or service that
3445 is a medically necessary covered benefit, based on the information available to the carrier at the
3446 time the request is made, including any facility fee, copayment, deductible or other out of pocket
3447 amount and the actual or maximum estimated allowed amount and co-insurance, for any covered
3448 health care benefits; provided, that the insured shall not be required to pay more than the
3449 disclosed amounts for the covered health care benefits; provided, however, that nothing in this
3450 section shall prevent carriers from imposing cost sharing requirements disclosed in the insured's
3451 evidence of coverage for unforeseen services that arise out of the proposed admission, procedure
3452 or service;

3453 (4) the locations where, and the manner in which, health care services and other benefits
3454 may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or
3455 service that is a medically necessary covered benefit is not available to an insured within the
3456 carrier's network, the carrier shall cover the out-of-network admission, procedure or service and
3457 the insured will not be responsible to pay more than the amount which would be required for
3458 similar admissions, procedures or services offered within the carrier's network; and (ii) an
3459 explanation that whenever a location is part of the carrier's network, that the carrier shall cover
3460 medically necessary covered benefits delivered at that location and the insured shall not be
3461 responsible to pay more than the amount required for network services even if part of the
3462 medically necessary covered benefits are performed by out-of-network providers unless the
3463 insured has a reasonable opportunity to choose to have the service performed by a network
3464 provider;.

3465 SECTION 138. Clause (1) of subsection (a) of section 7 of said chapter 176O, as so
3466 appearing, is hereby amended by striking out, in lines 18 and 19, the words “6 of chapter 118G”
3467 and inserting in place thereof the following words:- 11 of chapter 12C.

3468 SECTION 139. Said clause (1) of said subsection (a) of said section 7 of said chapter
3469 176O, as so appearing, is hereby further amended by striking out, in lines 20 and 21, the words
3470 “6 of said chapter 118G” and inserting in place thereof the following words:- 11 of said chapter
3471 12C.

3472 SECTION 140. Subsection (c) of section 9A of said chapter 176O, as so appearing, is
3473 hereby amended by striking out, in line 25, the words “6 of chapter 118G” and inserting in place
3474 thereof the following words:- 11 of chapter 12C; and.

3475 SECTION 141. Said section 9A of said chapter 176O, as so appearing, is hereby further
3476 amended by adding the following 2 subsections:-

3477 (d) limits the ability of either the carrier or the health care provider from disclosing the
3478 allowed amount and fees of services to an insured or insured’s treating health care provider.

3479 (e) limits the ability of either the carrier or the health care provider from disclosing out-
3480 of-pocket costs to an insured.

3481 SECTION 142. Subsection (a) of section 10 of said chapter 176O, as so appearing, is
3482 hereby amended by striking out, in line 2, the word “health”.

3483 SECTION 143. Said subsection (a) of said section 10 of said chapter 176O, as so
3484 appearing, is hereby further amended by inserting after the word “group”, in line 2, the following
3485 words:- or registered provider organization.

3486 SECTION 144. Section 12 of said chapter 176O, as so appearing, is hereby amended by
3487 striking out subsection (a) and inserting in place thereof the following subsection:-

3488 (a) Utilization review conducted by a carrier or a utilization review organization shall be
3489 conducted under a written plan, under the supervision of a physician and staffed by appropriately
3490 trained and qualified personnel and shall include a documented process to: (i) review and
3491 evaluate its effectiveness; (ii) ensure the consistent application of utilization review criteria; and
3492 (iii) ensure the timeliness of utilization review determinations.

3493 A carrier or utilization review organization shall adopt utilization review criteria and
3494 conduct all utilization review activities under said criteria. The criteria shall be, to the maximum
3495 extent feasible, scientifically derived and evidence-based, and developed with the input of
3496 participating physicians, consistent with the development of medical necessity criteria under
3497 section 16. Utilization review criteria shall be applied consistently by a carrier or a utilization
3498 review organization and made easily accessible and up-to-date on a carrier or utilization review
3499 organization's website to subscribers, health care providers and the general public. If a carrier or
3500 utilization review organization intends either to implement a new preauthorization requirement
3501 or restriction or amend an existing requirement or restriction, the carrier or utilization review
3502 organization shall ensure that the new or amended requirement or restriction shall not be
3503 implemented unless the carrier's or utilization review organization's website has been updated to
3504 reflect the new or amended requirement or restriction.

3505 Adverse determinations rendered by a program of utilization review or other denials of
3506 requests for health services, shall be made by a person licensed in the appropriate specialty

3507 related to such health service and, if applicable, by a provider in the same licensure category as
3508 the ordering provider.

3509 SECTION 145. Said section 12 of said chapter 176O, as so appearing, is hereby further
3510 amended by adding the following subsection:-

3511 (f) Upon request by an insured or insured's treating health care provider, a carrier or
3512 utilization review organization shall make a determination regarding whether a proposed
3513 admission, procedure or service is medically necessary within 2 working days of obtaining all
3514 necessary information, except that a carrier or utilization review organization may choose not to
3515 perform such a review if the carrier or utilization review organization determines that the
3516 admission, procedure or service will be covered. Nothing in this subsection shall require a
3517 treating health care provider to obtain information regarding whether a proposed admission,
3518 procedure or service is medically necessary on behalf of an insured.

3519 SECTION 146. Section 15 of said chapter 176O, as so appearing, is hereby amended by
3520 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
3521 "physician" and inserting in place thereof, in each instance, the following word:- provider.

3522 SECTION 147. Section 16 of said chapter 176O, as so appearing, is hereby amended by
3523 striking out subsection (b) and inserting in place thereof the following subsection:-

3524 (b) A carrier shall be required to pay for health care services ordered by a treating
3525 physician or a primary care provider if: (1) the services are a covered benefit under the insured's
3526 health benefit plan; and (2) the services are medically necessary. A carrier may develop
3527 guidelines to be used in applying the standard of medical necessity, as defined in this subsection.
3528 Any such medical necessity guidelines utilized by a carrier in making coverage determinations

3529 shall be: (i) developed with input from practicing physicians and participating providers in the
3530 carrier's or utilization review organization's service area; (ii) developed under the standards
3531 adopted by national accreditation organizations; (iii) updated at least biennially or more often as
3532 new treatments, applications and technologies are adopted as generally accepted professional
3533 medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier
3534 shall consider the individual health care needs of the insured. Any such medical necessity
3535 guidelines criteria shall be applied consistently by a carrier or a utilization review organization
3536 and made easily accessible and up-to-date on a carrier or utilization review organization's
3537 website to subscribers, health care providers and the general public. If a carrier or utilization
3538 review organization intends either to implement a new medical necessity guideline or amend an
3539 existing requirement or restriction, the carrier or utilization review organization shall ensure that
3540 the new or amended requirement or restriction shall not be implemented unless the carrier's or
3541 utilization review organization's website has been updated to reflect the new or amended
3542 requirement or restriction.

3543 SECTION 148. Subsection (c) of section 21 of said chapter 176O, as so appearing, is
3544 hereby amended by striking out, in lines 109 and 110, the words "division of health care finance
3545 and policy for use under section 6 of chapter 118G" and inserting in place thereof the following
3546 words:- institute of health care finance and policy for use under section 10 of chapter 12C.

3547 SECTION 149. Said section 21 of said chapter 176O, as so appearing, is hereby further
3548 amended by striking out subsection (d) and inserting in place thereof the following 2
3549 subsections:-

3550 (d) If a carrier reports a risk-based capital ratio on a combined entity basis under
3551 subsection (a) that exceeds 700 per cent, the division shall hold a public hearing within 60 days
3552 of receiving such report. The carrier shall submit testimony on how the carrier will dedicate any
3553 additional surplus above the 700 per cent level to reducing the cost of health benefit plans or for
3554 health care quality improvement, patient safety or health cost containment programs consistent
3555 with the activities of the health care quality and finance authority. The division shall review such
3556 testimony and issue a final report on the results of the hearing.

3557 (e) The commissioner may waive specific reporting requirements in this section for
3558 classes of carriers for which the commissioner deems such reporting requirements to be
3559 inapplicable; provided, however, that the commissioner shall provide written notice of any such
3560 waiver to the joint committee of health care financing and the house and senate committees on
3561 ways and means.

3562 SECTION 150. Said chapter 176O is hereby amended by adding the following 3
3563 sections:-

3564 Section 22. No carrier shall enter or renew an agreement or contract with any provider
3565 organization that is not registered under chapter 12C. Nothing herein shall require a carrier to
3566 negotiate a network contract with a registered provider organization, or with a registered
3567 provider organization for all providers that are part of, or represented by, a registered provider
3568 organization.

3569 Section 23. A provider organization registered under section 10 of chapter 12C which
3570 utilizes alternative payment methodologies, as defined in section 1 of said chapter 12C, shall
3571 create an internal appeals process. The internal appeals process shall be available to the public in

3572 a written format and by request in electronic format. The internal appeals process shall be
3573 completed in 14 days from the filing of the appeal; provided, that an expedited internal appeal
3574 process shall be completed in 3 days for a patient with a terminal illness or in emergency
3575 situations, as defined by regulations promulgated by the department of public health.

3576 A provider organization registered under section 10 of chapter 12C utilizing alternative
3577 payment methodologies shall offer options for external appeals in situations in which such
3578 options would be practical, under regulations promulgated by the department of public health.

3579 Section 24. (a) A payer or any entity acting for a payer under contract, when requiring
3580 prior authorization for a health care service or benefit, shall use and accept only the prior
3581 authorization forms designated for the specific types of services and benefits developed under
3582 subsection (c).

3583 (b) If a payer or any entity acting for a payer under contract fails to use or accept the
3584 required prior authorization form, or fails to respond within 2 business days after receiving a
3585 completed prior authorization request from a provider, pursuant to the submission of the prior
3586 authorization form developed as described in subsection (c), the prior authorization request shall
3587 be deemed to have been granted.

3588 (c) The division shall develop and implement uniform prior authorization forms for
3589 different health care services and benefits. The forms shall cover such health care services and
3590 benefits including, but not limited to, provider office visits, prescription drug benefits, imaging
3591 and other diagnostic testing, laboratory testing and any other health care services. The division
3592 shall develop forms for different kinds of services as it deems necessary or appropriate; provided
3593 that, all payers and any entities acting for a payer under contract shall use the uniform form

3594 designated by the division for the specific type of service. Six months after the full set of forms
3595 has been developed, every provider shall use the appropriate uniform prior authorization form to
3596 request prior authorization for coverage of the health care service or benefit and every payer or
3597 any entity acting for a payer under contract shall accept the form as sufficient to request prior
3598 authorization for the health care service or benefit.

3599 (d) The prior authorization forms developed under subsection (c) shall:

3600 (1) not exceed 2 pages;

3601 (2) be made electronically available; and

3602 (3) be capable of being electronically accepted by the payer after being
3603 completed.

3604 (e) The division, in developing the forms, shall:

3605 (1) seek input from interested stakeholders;

3606 (2) ensure that the forms are consistent with existing prior authorization forms
3607 established by the federal Centers for Medicare and Medicaid Services; and

3608 (3) consider other national standards pertaining to electronic prior authorization.

3609 SECTION 151. Section 1 of chapter 176Q of the General Laws, as appearing in the 2010
3610 Official Edition, is hereby amended by inserting after the definition of “connector seal of
3611 approval” the following definition:-

3612 “Dependent”, the spouse and children of any employee if such persons would qualify for
3613 dependent status under the Internal Revenue Code or for whom a support order could be granted
3614 under chapters 208, 209 or 209C.

3615 SECTION 152. Said section 1 of said chapter 176Q, as so appearing, is hereby further
3616 amended by striking out the definition of “division”.

3617 SECTION 153. Said section 1 of said chapter 176Q, as so appearing, is hereby further
3618 amended by inserting after the definition of “eligible small groups” the following 2 definitions:-

3619 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
3620 ends in the calendar year by which it is identified.

3621 “Free care”, the following medically necessary services provided to individuals
3622 determined to be financially unable to pay for their care, in whole or in part, under applicable
3623 regulations of the connector: (1) services provided by acute hospitals; (2) services provided by
3624 community health centers; and (3) patients in situations of medical hardship in which major
3625 expenditures for health care have depleted or can reasonably be expected to deplete the financial
3626 resources of the individual to the extent that medical services cannot be paid, as determined by
3627 regulations of the connector.

3628 SECTION 154. Said section 1 of said chapter 176Q, as so appearing, is hereby further
3629 amended by inserting after the definition of “mandated benefits” the following 2 definitions:-

3630 “Medically necessary services”, medically necessary inpatient and outpatient services as
3631 mandated under Title XIX of the Federal Social Security Act; provided, that “medically
3632 necessary services” shall not include: (1) non-medical services, such as social, educational and

3633 vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone
3634 conversations and consultations; (5) court testimony; (6) research or the provision of
3635 experimental or unproven procedures including, but not limited to, treatment related to sex-
3636 reassignment surgery, and pre-surgery hormone therapy; and (7) the provision of whole blood;
3637 and provided, however, that administrative and processing costs associated with the provision of
3638 blood and its derivatives shall be payable.

3639 “Non-providing employer”, an employer of a state-funded employee, as defined in this
3640 section; provided, however, that the term “non-providing employer” shall not include:—

3641 (i) an employer who complies with chapter 151F for such employee;

3642 (ii) an employer that is signatory to or obligated under a negotiated, bona fide
3643 collective bargaining agreement between such employer and bona fide employee representative
3644 which agreement governs the employment conditions of such person receiving free care;

3645 (iii) an employer who participates in the insurance reimbursement program; or

3646 (iv) an employer that employs not more than 10 employees.

3647 For the purposes of this definition, an employer shall not be considered to pay for or
3648 arrange for the purchase of health care services provided by acute hospitals and ambulatory
3649 surgical centers by making or arranging for any payments to the uncompensated care pool.

3650 SECTION 155. Said section 1 of said chapter 176Q, as so appearing, is hereby further
3651 amended by inserting after the definition of “participating institution” the following definition:-

3652 “Payments from non-providing employers”, all amounts paid to the Uncompensated Care
3653 Trust Fund or the General Fund or any successor fund by non-providing employers.

3654 SECTION 156. Said section 1 of said chapter 176Q, as so appearing, is hereby further
3655 amended by inserting after the definition of “rating factor” the following definition:-

3656 “State-funded employee”, any employed person, or dependent of such person, who
3657 receives, on more than 3 occasions during any hospital fiscal year, health services paid for as free
3658 care; or any employed persons, or dependents of such persons, of a company that has 5 or more
3659 occurrences of health services paid for as free care by all employees in aggregate during any
3660 fiscal year; provided that an occurrence shall include all healthcare related services incurred
3661 during a single visit to a health care professional.

3662 SECTION 157. Said section 1 of said chapter 176Q, as so appearing, is hereby further
3663 amended by inserting after the definition of “sub-connector” the following definition:-

3664 “Uninsured patient”, a patient who is not covered by a health insurance plan, a self-
3665 insurance health plan or a medical assistance program.

3666 SECTION 158. Subsection (m) of section 3 of chapter 176Q of the General Laws, as
3667 appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 84 and 85, the
3668 words “the board deems necessary to implement chapters 111M, 118G and 118H” and inserting
3669 in place thereof the following words:- , departments, commissions, authorities or political
3670 subdivisions the board considers necessary or appropriate to implement chapters 111M, 118E,
3671 118H and this chapter.

3672 SECTION 159. Said section 3 of said chapter 176 Q, as so appearing, is hereby further
3673 amended by adding the following subsection:-

3674 (u) to enter into contracts or agreements, at the board's discretion, with state departments,
3675 agencies, commissions, authorities, political subdivisions or any individuals, groups, non-profit
3676 or not-for-profit corporations, organizations or associations that are seeking affordable health
3677 insurance; provided further, that the connector shall serve as an agent or advisor to assist with or
3678 procure health insurance for said entities or persons. The board shall give preference to assisting
3679 non-profit or not-for-profit corporations or individuals, groups, organizations or associations
3680 seeking the connector's assistance for populations that have been historically uninsured or
3681 underinsured.

3682 SECTION 160. Chapter 176Q of the General Laws is hereby amended by striking out
3683 section 7A and inserting in place thereof the following section:-

3684 Section 7A. (a) There shall be a small group wellness incentive pilot program to expand
3685 the prevalence of employee wellness initiatives by small businesses. The program shall be
3686 administered by the board of the connector, in consultation with the department of public health.
3687 The program shall provide subsidies and technical assistance for eligible small groups to
3688 implement evidence-based employee health and wellness programs to improve employee health,
3689 decrease employer health costs and increase productivity.

3690 (b) An eligible small group shall be qualified to participate in the program if:

3691 (1) the eligible small group purchases group coverage through the connector;

3692 (2) the eligible small group enrolls in an evidence-based, employee wellness
3693 program offered through the connector;

3694 (3) the eligible small group meets certain minimum criteria, as determined by the
3695 connector board; and

3696 (4) the eligible small group meets certain minimum employee participation
3697 requirements in the qualified wellness program, as determined by the connector board, in
3698 collaboration with the department of public health.

3699 (c) For eligible small groups participating in the program, the connector shall provide an
3700 annual subsidy not to exceed 15 per cent of eligible employer health care costs as calculated by
3701 the connector board. If the director determines that funds are insufficient to meet the projected
3702 costs of enrolling new eligible employers, the director shall impose a cap on enrollment in the
3703 program.

3704 (d) The connector shall report annually to the joint committee on community
3705 development and small business, the joint committee on health care financing and the house and
3706 senate committees on ways and means on the enrollment in the small business wellness incentive
3707 program and evaluate the impact of the program on expanding wellness initiatives for small
3708 groups.

3709 (e) The connector shall promulgate regulations to implement this section.

3710 SECTION 161. Said chapter 176Q is hereby amended by adding the following 2
3711 sections:-

3712 Section 17. (a) The connector shall prepare a form, to be called the employer health
3713 insurance responsibility disclosure, on which an employer shall report whether it is in
3714 compliance with chapter 151F and any other information required by the connector relative to

3715 section 18 and paragraph (4) of subsection (a) of section 69 of chapter 118E. The form shall be
3716 completed, signed and returned to the institute by every employer with 11 or more full-time
3717 equivalent employees.

3718 (b) The connector shall prepare a form, to be called the employee health insurance
3719 responsibility disclosure, on which an employee of employers with 11 or more full-time
3720 equivalent employees who declines an employer-sponsored health plan shall report whether the
3721 employee has an alternative source of health insurance coverage. The form shall be completed
3722 and signed by the employee and shall be retained by the employer for 3 years. The institute may
3723 request a copy of the signed employee form.

3724 (c) Information that identifies individual employees by name or health insurance status
3725 shall not be a public record, but the information shall be exchanged with the department of
3726 revenue, the commonwealth health insurance connector authority and the health care access
3727 bureau in the division of insurance under an interagency services agreement to enforce this
3728 section, sections 3 to 7A, inclusive and sections 3, 6B and 18B of chapter 118H. An employer
3729 who knowingly falsifies or fails to file with the connector any information required by this
3730 section or by any regulation promulgated by the connector shall be punished by a fine of not less
3731 than \$1,000 not more than \$5,000.

3732 Section 18. (a) The connector shall, upon verification of the provision of services and
3733 costs to a state-funded employee, assess a free rider surcharge on the non-providing employer
3734 under regulations promulgated by the connector.

3735 (b) The amount of the free rider surcharge on non-providing employers shall be
3736 determined by the connector under regulations promulgated by the connector, and assessed by

3737 the connector not later than 3 months after the end of each hospital fiscal year, with payment by
3738 non-providing employers not later than 180 days after the assessment. The amount charged by
3739 the connector shall be greater than 10 per cent but not greater than 100 per cent of the cost to the
3740 state of the services provided to the state-funded employee, considering all payments received by
3741 the state from other financing sources for free care; provided that the “cost to the state” for
3742 services provided to any state-funded employee may be determined by the connector as a
3743 percentage of the state’s share of aggregate costs for health services. The free rider surcharge
3744 shall only be triggered upon incurring \$50,000 or more, in any hospital fiscal year, in free care
3745 services for any employer’s employees, or dependents of such persons, in aggregate, regardless
3746 of how many state-funded employees are employed by that employer.

3747 (c) The formula for assessing free rider surcharges on non-providing employers shall be
3748 set forth in regulations promulgated by the connector that shall be based on factors including, but
3749 not limited to: (i) the number of incidents during the past year in which employees of the non-
3750 providing employer received services reimbursed by the health safety net office under section 69
3751 of chapter 118E; (ii) the number of persons employed by the non-providing employer; (iii) the
3752 proportion of employees for whom the non-providing employer provides health insurance.

3753 (d) If a state-funded employee is employed by more than 1 non-providing employer at the
3754 time the employee receives services, the connector shall assess a free rider surcharge on each
3755 said employer consistent with the formula established by the connector under this section.

3756 (e) The connector shall specify by regulation appropriate mechanisms for implementing
3757 free rider surcharges on non-providing employers. Said regulations shall include, but not be
3758 limited to, the following:—

3759 (i) appropriate mechanisms that provide for determination and payment of
3760 surcharge by a non-providing employer including requirements for data to be submitted by
3761 employers, employees, acute hospitals and ambulatory surgical centers, and other persons; and

3762 (ii) penalties for nonpayment or late payment by the non-providing employer,
3763 including assessment of interest on the unpaid liability at a rate not to exceed an annual
3764 percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per
3765 month.

3766 (f) All surcharge payments made under this section shall be deposited into the
3767 Commonwealth Care Trust Fund, established by section 2000 of chapter 29.

3768 (g) A non-providing employer's liability to that fund shall in the case of a transfer of
3769 ownership be assumed by the successor in interest to the non-providing employer's.

3770 (h) If a non-providing employer fails to file any data, statistics or schedules or other
3771 information required under this chapter or by any regulation promulgated by the connector, the
3772 connector shall provide written notice of the required information. If the employer fails to
3773 provide information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be
3774 subject to a civil penalty of not more than \$5,000 for each week on which such violation occurs
3775 or continues, which penalty may be assessed in an action brought on behalf of the
3776 commonwealth in any court of competent jurisdiction.

3777 (i) The attorney general shall bring any appropriate action, including injunctive relief, as
3778 may be necessary for the enforcement of this section.

3779 (j) No employer shall discriminate against any employee on the basis of the employee's
3780 receipt of free care, the employee's reporting or disclosure of the employer's identity and other
3781 information about the employer, the employee's completion of a Health Insurance Responsibility
3782 Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed
3783 against the employer in relation to the employee. Violation of this subsection shall constitute a
3784 per se violation of chapter 93A.

3785 (k) A hospital, surgical center, health center or other entity that provides health safety net
3786 services shall provide an uninsured patient with written notice of the criminal penalties for
3787 committing fraud in connection with the receipt of health safety net services. The connector shall
3788 promulgate a standard written notice form to be made available to health care providers in
3789 English and foreign languages. The form shall further include written notice of every employee's
3790 protection from employment discrimination under this section.

3791 SECTION 162. The General Laws are hereby amended by inserting, after chapter 176R
3792 the following 2 chapters:

3793 CHAPTER 176S

3794 COMMONWEALTH HEALTH CARE QUALITY AND FINANCE AUTHORITY

3795 Section 1. As used in this chapter the following words shall, unless the context clearly
3796 requires otherwise, have the following meanings:-

3797 "Actual economic growth benchmark," the actual annual percentage change in the per
3798 capita state's gross state product, excluding the impact of business cycles, as established under
3799 section 7H½ of chapter 29.

3800 “Acute hospital,” the teaching hospital of the University of Massachusetts Medical
3801 School and any hospital licensed under section 51 of chapter 111 and which contains a majority
3802 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of
3803 public health.

3804 “Alternative payment contract”, any contract between a provider or provider organization
3805 and a public health care payer or a private health care payer which utilizes alternative payment
3806 methodologies.

3807 “Alternative payment methodologies”, methods of payment that are not directly fee-for-
3808 service reimbursement for services; provided, that “alternative payment methodologies” may
3809 include, but not be limited to, global payments, shared savings arrangements, bundled payments
3810 and episodic payments.

3811 “Authority”, the commonwealth health care quality and finance authority.

3812 “Beacon ACO”, a certification given by the board of the authority to indicate that a
3813 provider organization meets certain standards regarding quality, cost containment and patient
3814 protection.

3815 “Board”, the board of the commonwealth health care quality and finance authority,
3816 established by section 2.

3817 “Business entity”, a corporation, association, partnership, limited liability company,
3818 limited liability partnership or other legal entity.

3819 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health
3820 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter

3821 176A; a nonprofit medical service corporation organized under chapter 176B; a health
3822 maintenance organization organized under chapter 176G; and an organization entering into a
3823 preferred provider arrangement under chapter 176I, but not including an employer purchasing
3824 coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or
3825 affiliated corporations of the employer; provided that, unless otherwise noted, the term “carrier”
3826 shall not include any entity to the extent it offers a policy, certificate or contract that provides
3827 coverage solely for dental care services or visions care services.

3828 “Facility,” a licensed institution providing health care services or a health care setting,
3829 including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical
3830 or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory
3831 and imaging centers and rehabilitation and other therapeutic health settings.

3832 "Fee-for-service", a form of contract under which a provider or provider organization is
3833 paid for discrete and separate units of service and each provider is separately reimbursed for each
3834 discrete service rendered to a patient; provided, however, that up to 10 per cent of total
3835 reimbursement under such contracts may depend on the achievement of certain targets of
3836 performance or conduct.

3837 “Institute”, the institute of health care finance and policy established in chapter 12C.

3838 “Health benefit plan”, any individual, general, blanket or group policy of health, accident
3839 and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service
3840 plan issued by a non-profit hospital service corporation under chapter 176A; a group medical
3841 service plan issued by a non-profit medical service corporation under chapter 176B; a group
3842 health maintenance contract issued by a health maintenance organization under chapter 176G; a

3843 coverage for young adults health insurance plan under section 10 of chapter 176J; provided that
3844 “health benefit plan” shall not include accident only, credit-only, limited scope vision or dental
3845 benefits if offered separately, hospital indemnity insurance policies if offered as independent,
3846 non-coordinated benefits which for the purposes of this chapter shall mean policies issued under
3847 chapter 175 which provide a benefit not to exceed \$500 per day, as adjusted on an annual basis
3848 by the amount of increase in the average weekly wages in the commonwealth as defined in
3849 section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an
3850 insured, on the basis of a hospitalization of the insured or a dependent, disability income
3851 insurance, coverage issued as a supplement to liability insurance, specified disease insurance that
3852 is purchased as a supplement and not as a substitute for a health plan and meets any requirements
3853 the commissioner of insurance by regulation may set, insurance arising out of a workers
3854 compensation law or similar law, automobile medical payment insurance, insurance under which
3855 benefits are payable with or without regard to fault and which is statutorily required to be
3856 contained in a liability insurance policy or equivalent self insurance, long-term care if offered
3857 separately, coverage supplemental to the coverage provided under 10 U.S.C. section 55 if offered
3858 as a separate insurance policy, or any policy subject to chapter 176K or any similar policies
3859 issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans;
3860 provided, further that “health benefit plan” shall not include a health plan issued, renewed or
3861 delivered within or without the commonwealth to an individual who is enrolled in a qualifying
3862 student health insurance program under section 18 of chapter 15A which shall be governed by
3863 said chapter 15A; provided, further that the authority may by regulation define other health
3864 coverage as a health benefit plan for the purposes of this chapter.

3865 “Health care cost growth benchmark,” the projected annual percentage change in total
3866 health care expenditures in the commonwealth, as established in section 5.

3867 “Health care entity”, a provider, provider organization or carrier.

3868 “Health care professional,” a physician or other health care practitioner licensed,
3869 accredited or certified to perform specified health services consistent with law.

3870 “Health care services,” services for the diagnosis, prevention, treatment, cure or relief of
3871 a health condition, illness, injury or disease.

3872 “Health status adjusted total medical expenses”, the total cost of care for the patient
3873 population associated with a provider group based on allowed claims for all categories of
3874 medical expenses and all non-claims related payments to providers, adjusted by health status and
3875 expressed on a per member per month basis, as calculated under section 9 of chapter 12C.

3876 “Major service category,” a set of service categories to be established by regulation,
3877 which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii)
3878 outpatient and ambulatory services, by categories as defined by the Centers for Medicare and
3879 Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all
3880 other” outpatient and ambulatory services that do not fall within a defined category; (iii)
3881 behavioral and mental health services by categories as defined by the Centers for Medicare and
3882 Medicaid, or as established by regulation; (iv) professional services, by categories as defined by
3883 the Centers for Medicare and Medicaid, or as established by regulation; and (v) sub-acute
3884 services, by major service line or clinical offering, as defined by regulation.

3885 “Medicaid program”, the medical assistance program administered by the division of
3886 medical assistance under chapter 118E and in accordance with Title XIX of the Federal Social
3887 Security Act or any successor statute.

3888 “Medicare program”, the medical insurance program established by Title XVIII of the
3889 Social Security Act.

3890 “Performance improvement plan,” a plan submitted to the authority by a carrier, a
3891 provider or a provider organization under section 7, which shall be kept confidential by the board
3892 and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4
3893 or chapter 66.

3894 “Projected economic growth benchmark,” the long-term average projected percentage
3895 change in the per capita state’s gross state product, excluding the impact of business cycles, as
3896 established under section 7H½ of chapter 29.

3897 “Provider,” a health care professional or a facility.

3898 “Provider organization,” any corporation, partnership, business trust, association or
3899 organized group of persons whether incorporated or not that consists of or represents 1 or more
3900 providers in contracting with carriers for the payments the provider or providers receive for the
3901 provision of health care services; provided, that “provider organization” shall include, but not be
3902 limited to, physician organizations, physician-hospital organizations, independent practice
3903 associations, accountable care organizations, provider networks and any other organization that
3904 contracts with carriers for payment for health care services.

3905 “Specialty hospital,” an acute hospital which qualifies for an exemption from the
3906 Medicare prospective payment system regulations or any acute hospital which limits its
3907 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to
3908 children or patients under obstetrical care.

3909 “Total health care expenditures”, the annual per capita sum of all health care expenditures
3910 in the commonwealth, including public and private sources.

3911 Section 2. (a) There shall be a body politic and corporate and a public instrumentality to
3912 be known as the commonwealth health care quality and finance authority, which shall be an
3913 independent public entity not subject to the supervision and control of any other executive office,
3914 department, commission, board, bureau, agency or political subdivision of the commonwealth
3915 except as specifically provided in any general or special law. The exercise by the authority of the
3916 powers conferred by this chapter shall be considered to be the performance of an essential public
3917 function. The purpose of the authority shall be to set health care cost containment goals for the
3918 commonwealth and to foster innovative health care delivery and payment models that lower
3919 health care cost growth while improving the quality of patient care.

3920 (b) There shall be a board, with duties and powers established by this chapter, that shall
3921 govern the authority. The authority’s board shall consist of 11 members: the secretary of
3922 administration and finance, ex officio; the secretary of health and human services, ex officio; the
3923 secretary of housing and economic development, ex officio; 1 other member appointed by the
3924 governor whom shall be an expert in health care delivery and payment models; 3 members
3925 appointed by the attorney general, 1 of whom shall be a health economist, 1 of whom shall
3926 represent the interests of businesses and 1 of whom shall have experience in the administration

3927 of a health care provider organization; 3 members appointed by the state auditor, 1 of whom
3928 shall be an expert in behavioral health services and behavioral health reimbursement systems, 1
3929 of whom shall be a representative of a health consumer organization and 1 of whom shall be a
3930 representative of organized labor. The governor, attorney general and the auditor shall, by
3931 majority vote, jointly appoint 1 member who is an expert in health care finance and policy in the
3932 commonwealth, to act as the chair. All members shall serve a term of 3 years, but a member
3933 appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the
3934 board shall be eligible for reappointment. The board shall annually elect 1 of its members to
3935 serve as the vice-chairperson. Each member of the board serving ex officio may appoint a
3936 designee under section 6A of chapter 30.

3937 (c) A member of the board shall not be employed by, a consultant to, a member of the
3938 board of directors of, affiliated with, have a financial stake in or otherwise be a representative of
3939 a health care entity while serving on the board.

3940 (d) Six members of the board shall constitute a quorum and the affirmative vote of 6
3941 members of the board shall be necessary and sufficient for any action taken by the board. No
3942 vacancy in the membership of the board shall impair the right of a quorum to exercise all the
3943 rights and duties of the connector. Members shall serve without pay but shall be reimbursed for
3944 actual expenses necessarily incurred in the performance of their duties. The chairperson of the
3945 board shall report to the governor and to the general court not less frequently than annually.

3946 (e) Any action of the authority may take effect immediately and need not be published or
3947 posted unless otherwise provided by law. Meetings of the board shall be subject to section 11A
3948 of chapter 30A; but, said section 11A shall not apply to any meeting of members of the board

3949 serving ex officio in the exercise of their duties as officers of the commonwealth if no matters
3950 relating to the official business of the authority are discussed and decided at the meeting. The
3951 authority shall be subject to all other provisions of said chapter 30A and records pertaining to the
3952 administration of the authority shall be subject to section 42 of chapter 30 and section 10 of
3953 chapter 66. All moneys of the authority shall be considered to be public funds for purposes of
3954 chapter 12A. The operations of the authority shall be subject to chapter 268A and chapter 268B.

3955 (f) The chairperson shall hire an executive director to supervise the administrative affairs
3956 and general management and operations of the authority and also serve as secretary of the
3957 authority, ex officio. The executive director shall receive a salary commensurate with the duties
3958 of the office. The executive director may appoint other officers and employees of the authority
3959 necessary to the functioning of the authority. Sections 9A, 45, 46 and 46C of chapter 30, chapter
3960 31 and chapter 150E shall not apply to the executive director or any other employees of the
3961 authority. The executive director shall, with the approval of the board:

3962 (i) plan, direct, coordinate and execute administrative functions in conformity
3963 with the policies and directives of the board;

3964 (ii) employ professional and clerical staff as necessary;

3965 (iii) report to the board on all operations under the executive director's control
3966 and supervision;

3967 (iv) prepare an annual budget and manage the administrative expenses of the
3968 authority; and

3969 (v) undertake any other activities necessary to implement the powers and duties
3970 under this chapter.

3971 Section 3. The board of the authority shall set health care cost containment goals for the
3972 commonwealth and foster the innovation of health care delivery and payment models that lower
3973 health care cost growth while improving the quality of patient care. The board shall have all
3974 powers necessary or convenient to carry out and effectuate its purposes including, but not limited
3975 to, the power to:

3976 (a) to develop a plan of operation for the authority, which shall include, but not be limited
3977 to:

3978 (1) establishing procedures for operations of the authority;

3979 (2) establishing procedures for communications with the executive director;

3980 (3) establishing procedures for setting an annual health care cost growth
3981 benchmark;

3982 (4) holding annual hearings concerning the growth in total health care
3983 expenditures relative to the health care cost benchmark, including an examination of health care
3984 provider, provider organization and payer costs, prices and health status adjusted total medical
3985 expense trends;

3986 (5) providing an annual report on recommendations for strategies to meet future
3987 annual health care cost growth benchmarks and to promote an efficient health delivery system;

3988 (6) establishing procedures that, in the event the annual health care cost growth
3989 benchmark is exceeded, require certain health care entities to file a performance improvement
3990 plan and the procedures for approving said plan;

3991 (7) establishing procedures for monitoring compliance and implementation by a
3992 health care entity of a performance improvement plan, including standards to ascertain whether a
3993 health care entity has failed to implement a performance improvement plan in good faith;

3994 (8) establishing procedures and developing criteria for the certification of certain
3995 provider organizations as Beacon ACOs, based on standards related to cost containment, quality
3996 improvement and patient protections;

3997 (9) establishing procedures to decertify certain provider organizations as Beacon
3998 ACOs;

3999 (10) developing best practices and standards for alternative payment
4000 methodologies to be adopted by the office of Medicaid, the group insurance commission and
4001 other state-funded health insurance programs;

4002 (11) fostering health care innovation by identifying, developing, supporting and
4003 evaluating health care delivery and payment reform models and best practices, in consultation
4004 with health care entities, that reduce health care cost growth while improving the quality of
4005 patient care; and

4006 (12) administering the Healthcare Payment Reform Fund, established under
4007 section 100 of chapter 194 of the acts of 2011, to support the activities of the authority;

4008 (b) to adopt by-laws for the regulation of its affairs and the conduct of its business;

4009 (c) to adopt an official seal and alter the same;

4010 (d) to maintain an office at such place or places in the commonwealth as it may

4011 designate;

4012 (e) to sue and be sued in its own name, plead and be impleaded;

4013 (f) to establish lines of credit, and establish 1 or more cash and investment accounts to

4014 receive payments for services rendered, appropriations from the commonwealth and for all other

4015 business activity granted by this chapter except to the extent otherwise limited by any applicable

4016 provision of the Employee Retirement Income Security Act of 1974;

4017 (g) to approve the use of its trademarks, brand names, seals, logos and similar

4018 instruments by participating carriers, employers or organizations; and

4019 (h) to enter into interdepartmental agreements with the institute of health care finance and

4020 policy, the executive office of health and human services, the division of insurance and any other

4021 state agencies the board considers necessary.

4022 Section 4. There shall be an advisory board to the authority. The advisory board shall

4023 advise on the overall operation and policy of the authority. The advisory board shall consist of 7

4024 ex-officio members, including the state auditor, the inspector general, the attorney general, the

4025 commissioner of insurance, the executive director of the institute of health care finance and

4026 policy, the commissioner of public health and the executive director of the group insurance

4027 commission, or their designees; and 11 additional members to be appointed by the governor, 1 of

4028 whom shall be a representative of a health care quality improvement organization recognized by

4029 the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of

4030 the Institute for Healthcare Improvement recommended by the organization's board of directors,
4031 1 of whom shall be a representative of the Massachusetts chapter of the National Association of
4032 Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts
4033 Association of Health Underwriters, Inc., 1 of whom shall be a representative of the
4034 Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy
4035 from a foundation or academic institution, 1 of whom shall be a representative of a non-
4036 governmental purchaser of health insurance, 1 of whom shall be an organization representing the
4037 interests of small businesses with fewer than 50 employees, 1 of whom shall be an organization
4038 representing the interests of large businesses with 50 or more employees, 1 of whom shall be a
4039 physician licensed to practice in the commonwealth and 1 of whom shall be a non-physician
4040 health care professional licensed to practice in the commonwealth.

4041 Section 5. (a) Not later than April 15 of every year, the board shall establish a health care
4042 cost growth benchmark for the average growth in total health care expenditures in the
4043 commonwealth for the next calendar year. The authority shall establish procedures to
4044 prominently publish the annual health care cost growth benchmark on the authority's website.

4045 (b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal
4046 to the economic growth benchmark established under section 7H½ of chapter 29, plus 0.5%.

4047 (c) For calendar years 2016-2022, the health care cost growth benchmark shall be equal
4048 to the economic growth benchmark established under section 7H½ of chapter 29.

4049 (c) For calendar years 2027 and thereafter, the health care cost growth benchmark shall
4050 be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus
4051 1%.

4052 Section 6. (a) Not later than October 1 of every year, the board shall hold public hearings
4053 based on the report submitted by the institute under section 15 of chapter 12C comparing the
4054 growth in total health care expenditures to the health care cost growth benchmark for the
4055 previous calendar year. The hearings shall examine health care provider, provider organization
4056 and private and public health care payer costs, prices, and cost trends, with particular attention to
4057 factors that contribute to cost growth within the commonwealth's health care system. The
4058 attorney general may intervene in such hearings.

4059 (b) Public notice of any hearing shall be provided at least 60 days in advance.

4060 (c) The authority shall identify as witnesses for the public hearing a representative sample
4061 of providers, provider organizations and payers, including: (i) at least 3 academic medical
4062 centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii)
4063 at least 3 disproportionate share hospitals, including the 2 hospitals whose largest per cent of
4064 gross patient service revenue is attributable to Title XVIII and XIX of the federal Social Security
4065 Act or other governmental payers; (iii) community hospitals from at least 3 separate regions of
4066 the state; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the
4067 state; (v) community health centers from at least 3 separate regions of the state; (vi) the 5 private
4068 health care payers with the highest enrollments in the state; (vii) any managed care organization
4069 that provides health benefits under Title XIX or under the commonwealth care health insurance
4070 program; (viii) the group insurance commission; (ix) at least 3 municipalities that have adopted
4071 chapter 32B; (x) at least 3 provider organizations, at least 1 of which shall be a physician
4072 organization and at least 1 of which has been certified as a Beacon ACO; and (xii) any witness
4073 identified by the attorney general or the institute of health care finance and policy.

4074 (d) Witnesses shall provide testimony under oath and subject to examination and cross
4075 examination by the board, the executive director of the institute and the attorney general at the
4076 public hearing in a manner and form to be determined by the board, including without limitation:
4077 (i) in the case of providers and provider organizations, testimony concerning payment systems,
4078 care delivery models, payer mix, cost structures, administrative and labor costs, capital and
4079 technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization
4080 trends, relative price, quality improvement and care-coordination strategies, investments in
4081 health information technology, the relation of private payer reimbursement levels to public payer
4082 reimbursements for similar services, efforts to improve the efficiency of the delivery system and
4083 efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private
4084 and public payers, testimony concerning factors underlying premium cost and rate increases, the
4085 relation of reserves to premium costs, the payer's efforts to develop benefit design, network
4086 design and payment policies that enhance product affordability and encourage efficient use of
4087 health resources and technology including utilization of alternative payment methodologies,
4088 efforts by the payer to increase consumer access to health care information, efforts by the payer
4089 to reduce price variance between providers, efforts by the payer to promote the standardization
4090 of administrative practices and any other matters as determined by the board.

4091 (e) In the event that the institute's annual report under section 15 of chapter 12C finds
4092 that the percentage change in total health care expenditures exceeded the health care cost
4093 benchmark in the previous calendar year, the authority may identify additional witnesses for the
4094 public hearing. Witnesses shall provide testimony subject to examination and cross examination
4095 by the board, the executive director of the institute and attorney general at the public hearing in a
4096 manner and form to be determined by the board, including without limitation: (i) testimony

4097 concerning unanticipated events that may have impacted the total health care cost expenditures,
4098 including, but not limited to, a public health crisis such as an outbreak of a disease, a public
4099 safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity
4100 or utilization of services; (iii) testimony concerning trends in input cost structures, including, but
4101 not limited to, the introduction of new pharmaceuticals, medical devices and other health
4102 technologies; (iv) testimony concerning the cost of providing certain specialty services, including
4103 but not limited to, the provision of health care to children, the provision of cancer-related health
4104 care and the provision of medical education; (v) testimony related to unanticipated administrative
4105 costs for carriers, including, but not limited to, costs related to information technology,
4106 administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related
4107 to costs due the implementation of state or federal legislation or government regulation; and (vii)
4108 any other factors that may have led to excessive health care cost growth.

4109 (f) The authority shall compile an annual report concerning spending trends and
4110 underlying factors, along with any recommendations for strategies to increase the efficiency of
4111 the health care system. The report shall be based on the authority's analysis of information
4112 provided at the hearings by providers, provider organizations and insurers, data collected by the
4113 institutes under sections 9 t10 and11 of chapter 12C, and any other information the authority
4114 considers necessary to fulfill its duties under this section, as further defined in regulations
4115 promulgated by the authority. The report shall be submitted to the chairs of the house and senate
4116 committees on ways and means, the chairs of the joint committee on health care financing and
4117 shall be published and available to the public not later than December 31 of each year. The
4118 report shall include any legislative language necessary to implement the recommendations.

4119 Section 7. (a) The authority shall provide confidential notice to health care entities whose
4120 increase in health status adjusted total medical expense is considered excessive and who threaten
4121 the ability of the state to meet the health care cost growth benchmark as identified by the institute
4122 under section 16 of chapter 12C. Such notice shall state that the health care entity has been
4123 identified as having an excessive increase in health status adjusted total medical expense.

4124 (b) For calendar year 2015, in the event that the institute's annual report under section 15
4125 of chapter 12C finds that average percentage change in cumulative total health care expenditures
4126 from 2012 to 2014 exceeded the average health care cost benchmark from 2012 to 2014, and in
4127 order to support the state's efforts to meet future health care cost growth benchmarks, as
4128 established in section 5, the authority shall establish procedures to assist health care entities to
4129 improve efficiency and reduce cost growth through the requirement of certain health care entities
4130 to file and implement a performance improvement plan.

4131 Beginning in calendar year 2016, in the event that the institute's annual report under said
4132 section 15 of said chapter 12C finds that percentage change in total health care expenditures
4133 exceeded the health care cost benchmark in the previous calendar year, and in order to support
4134 the state's efforts to meet future health care cost growth benchmarks, as established in said
4135 section 5, the authority shall establish procedures to assist health care entities to improve
4136 efficiency and reduce the cost growth through the requirement of certain health care entities to
4137 file and implement a performance improvement plan.

4138 (c) In addition to the confidential notice provided under subsection (a), the authority may
4139 provide confidential notice to the health care entity that it will be required to file a performance

4140 improvement plan. Within 45 days of receiving this notice from the authority, the health care
4141 entity shall either:

4142 (1) file a confidential performance improvement plan with the authority; or

4143 (2) file a confidential application with the authority to waive or extend the
4144 requirement to file a performance improvement plan. The health care entity may file any
4145 documentation or supporting evidence with the authority to support the health care entity's
4146 application to waive or extend the requirement to file a performance improvement plan. The
4147 authority shall require the health care entity to submit any other relevant information it deems
4148 necessary in considering the waiver or extension application.

4149 All information submitted shall remain confidential and exempt from disclosure under
4150 clause Twenty-sixth of section 7 of chapter 4 and chapter 66.

4151 (d) The authority may waive or delay the requirement for a health care entity to file a
4152 performance improvement plan in response to a waiver or extension request filed under
4153 paragraph (2) of subsection (c) based on a consideration of the following factors, in light of all
4154 information received from the health care entity:

4155 (1) the costs, price and utilization trends of the health care entity over time, and
4156 any demonstrated improvement to reduce health status adjusted total medical expenses;

4157 (2) any ongoing strategies or investments that the health care entity is
4158 implementing to improve future long-term efficiency and reduce cost growth;

4159 (3) whether the factors that led to increased costs for the health care entity can
4160 reasonably be considered to be outside of the control of the entity and unanticipated;

- 4161 (4) the overall financial condition of the health care entity;
- 4162 (5) the proportionate impact of the health care entity's costs on the growth of total
4163 health care medical expenses statewide;
- 4164 (6) a significant deviation between the projected economic growth benchmark and
4165 the actual economic growth benchmark, as established under section 7H½ of chapter 29; and
- 4166 (7) any other factors the authority considers relevant, including any information or
4167 testimony collected by the authority under the subsection (e) of section 6.

4168 If the authority declines to waive or extend the requirement for the health care entity to
4169 file a performance improvement plan, the authority shall provide confidential notice to the health
4170 care entity that its application for a waiver or extension was denied and the health care entity
4171 shall file a performance improvement plan within 45 days.

4172 (e) A health care entity shall file a performance improvement plan: (i) within 45 days of
4173 receipt of a notice under subsection (c); (ii) if the health care entity has requested a waiver or
4174 extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or
4175 (iii) if the health care entity is granted an extension, on the date given on such extension. The
4176 performance improvement plan shall be generated by the health care entity and shall identify the
4177 causes of the entity's cost growth and shall include, but not be limited to, specific strategies,
4178 adjustments and action steps the entity proposes to implement to improve cost performance, as
4179 measured by health status adjusted total medical expenses. The proposed performance
4180 improvement plan shall include specific identified and measurable expected outcomes and a
4181 timetable for implementation. The timetable for a performance improvement plan shall not
4182 exceed 18 months.

4183 (f) The authority shall approve any performance improvement plan that it determines is
4184 reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable
4185 expectation for successful implementation.

4186 (g) If the board determines that the performance improvement plan is unacceptable or
4187 incomplete, the authority may provide consultation on the criteria that have not been met and
4188 may allow an additional time period, up to 30 calendar days, for resubmission; provided
4189 however, that all aspects of the performance improvement plan shall be proposed by the health
4190 care entity and the authority shall not require specific elements for approval.

4191 (h) Upon approval of the proposed performance improvement plan, the authority shall
4192 notify the health care entity to begin immediate implementation of the performance improvement
4193 plan. Public notice shall be provided by the authority on its website identifying that the health
4194 care entity is implementing a performance improvement plan; provided however, that the
4195 performance improvement plan itself shall remain confidential. All health care entities
4196 implementing an approved performance improvement plan shall be subject to additional
4197 confidential reporting requirements and compliance monitoring, as determined by the authority.
4198 The authority shall provide assistance to the health care entity in the successful implementation
4199 of the performance improvement plan.

4200 (i) All health care entities shall, in good faith, work to implement the performance
4201 improvement plan. At any point during the implementation of the performance improvement
4202 plan the health care entity may file amendments to the performance improvement plan, subject to
4203 approval of the authority.

4204 (j) At the conclusion of the timetable established in the performance improvement plan,
4205 the health care entity shall report to the authority regarding the outcome of the performance
4206 improvement plan. If the performance improvement plan was found to be unsuccessful, the
4207 authority shall either: (i) extend the implementation timetable of the existing performance
4208 improvement plan; (ii) approve amendments to the performance improvement plan as proposed
4209 by the health care entity; (iii) require the health care entity to submit a new performance
4210 improvement plan under subsection (e); or (iv) waive or delay the requirement to file any
4211 additional performance improvement plans.

4212 (k) Upon the successful completion of the performance improvement plan, or a decision
4213 by the board to waive or delay the requirement to file a new performance improvement plan, the
4214 identity of the health care entity shall be removed from the authority's website.

4215 (l) If the authority determines that a health care entity has: (i) willfully neglected to file a
4216 performance improvement plan with the authority within 45 days as required under subsection
4217 (e); (ii) failed to file an acceptable performance improvement plan in good faith with the
4218 authority; (iii) failed to implement the performance improvement plan in good faith; or (iv)
4219 knowingly failed to provide information required by this section to the authority or that
4220 knowingly falsifies the same, the authority may assess a civil penalty to the health care entity of
4221 not more than \$500,000. The authority shall seek to promote compliance with this section and
4222 shall only impose a civil penalty as a last resort.

4223 (m) The authority may submit a recommendation of proposed legislation to the joint
4224 committee on health care financing if the authority believes that further legislative authority is

4225 needed to assist health care entities to implement successful performance improvement plans or
4226 to ensure compliance under this section.

4227 (n) The authority shall promulgate regulations as necessary to implement this section;
4228 provided however, that notice of any proposed regulations shall be filed with the joint committee
4229 on state administration and the joint committee on health care financing at least 180 days before
4230 adoption.

4231 Section 8. (a) The authority, in consultation with the advisory board, shall develop
4232 standards and a common application form for certain provider organizations to be voluntarily
4233 certified as Beacon ACOs. The purpose of the Beacon ACO certification process shall be to
4234 encourage the adoption of certain best practices by provider organizations in the commonwealth
4235 related to cost containment, quality improvement and patient protection. Provider organizations
4236 seeking this certification shall apply directly to the authority and shall submit all necessary
4237 documentation as required by the authority. The Beacon ACO certification shall be assigned to
4238 all provider organizations that meet the standards developed by the board.

4239 (b) In developing standards for Beacon ACO certification, the authority shall include a
4240 review of the best practices employed by health care entities in the commonwealth, and at a
4241 minimum, all applicable requirements developed by the Centers for Medicare & Medicaid
4242 Services under the Pioneer ACO model, including, but not limited to, requirements that all
4243 Beacon ACOs shall: (i) commit to entering alternative payment methodology contracts with
4244 other purchasers such that the majority of the Beacon ACO's total revenues will be derived from
4245 such arrangements; (ii) be a legal entity with its own tax identification number, recognized and
4246 authorized under the laws of the commonwealth; (iii) include patient and consumer

4247 representation on its governance; and (iv) commit to ensuring at least 50 per cent of the Beacon
4248 ACO's primary care providers are meaningfully using certified EHR technology as defined in
4249 the HITECH Act and subsequent Medicare regulations.

4250 (c) The board shall develop additional standards necessary to be certified as a Beacon
4251 ACO, related to quality improvement, cost containment and patient protections. In developing
4252 additional standards, the board shall consider, at a minimum, the following requirements for
4253 Beacon ACOs:

4254 (1) to reduce the growth of health status adjusted total medical expenses over
4255 time, consistent with the state's efforts to meet the health care cost benchmark established under
4256 section 5;

4257 (2) to improve the quality of health services provided, as measured by the
4258 statewide quality measure set and other appropriate measures;

4259 (3) to ensure patient access to health care services across the care continuum,
4260 including, but not limited to, access to: preventive and primary care services; emergency
4261 services; hospitalization services; ambulatory patient services; mental health and behavioral
4262 health services; access to specialty care units, including, but are not limited to, burn, coronary
4263 care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care,
4264 renal dialysis and surgical, including trauma and intensive care units; pediatric services;
4265 diagnostic imaging and screening services; maternity and newborn care services; radiation
4266 therapy and treatment services; skilled nursing facilities; family planning services; home health
4267 services; treatment and prevention services for alcohol and other drug abuse; breakthrough
4268 technologies and treatments; and allied health services including, but not limited to, advance

4269 practice nurses, optometric care, direct access to chiropractic services, occupational therapists,
4270 dental care, physical therapy and midwifery services;

4271 (4) to improve access to certain primary care services, including but not limited
4272 to, by having a demonstrated primary care capacity and a minimum number of practices engaged
4273 in becoming patient centered medical homes;

4274 (5) to improve access to health care services and quality of care for vulnerable
4275 populations including, but not limited to, children, the elderly, low-income individuals,
4276 individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities.

4277 (6) to promote the integration of mental health and behavioral health services with
4278 primary care services including, but not limited to, the establishment of a behavioral health
4279 medical home;

4280 (7) to promote patient-centeredness by, including, but not limited to, establishing
4281 mechanisms to conduct patient outreach and education on the necessity and benefits of care
4282 coordination; demonstrating an ability to engage patients in shared decision making taking into
4283 account patient preferences; demonstrating an ability to effectively involve patients in care
4284 transitions to improve the continuity and quality of care across settings, with case manager
4285 follow up; demonstrating an ability to engage and activate patients at home, through methods
4286 such as home visits or telemedicine, to improve self-management; and establishing mechanisms
4287 to evaluate patient satisfaction with the access and quality of their care;

4288 (8) to adopt certain health information technology and data analysis functions,
4289 including, but not limited to, population-based management tools and functions; the ability to
4290 aggregate and analyze clinical data; the ability to electronically exchange patient summary

4291 records across providers who are members of the Beacon ACO and other providers in the
4292 community to ensure continuity of care; the ability to provide access to multi-payer claims data
4293 and performance reports and the ability to share performance feedback on a timely basis with
4294 participating providers; and the ability to enable the beneficiary access to electronic health
4295 information;

4296 (9) to demonstrate excellence in the area of quality improvement and care
4297 coordination, as evidenced by the success of previous or existing care coordination, pay for
4298 performance, patient centered medical home, quality improvement or health outcomes
4299 improvement initiatives, including, but not limited to, a demonstrated commitment to reducing
4300 avoidable hospitalizations, adverse events and unnecessary emergency room visits;

4301 (10) to promote community-based wellness programs and community health
4302 workers, consistent with efforts funded by the department of public health through the
4303 Prevention and Wellness Trust Fund established in section 2G of chapter 111;

4304 (11) to promote worker training programs and skills training opportunities for
4305 employees of the provider organization, consistent with efforts funded by the secretary of labor
4306 and workforce development through the Health Care Workforce Transformation Trust Fund;

4307 (12) to adopt certain governance structure standards;

4308 (13) to adopt certain financial capacity standards, including certification under
4309 subsection (e) of section 10 of chapter 12C, to protect Beacon ACOs from assuming excess risk;
4310 and

4311 (14) any other requirements the board considers necessary.

4312 (d) The authority shall update the standards for certification as a Beacon ACO at least
4313 every 2 years, or at such other times as the authority determines necessary. In developing the
4314 standards, the authority shall seek to allow for provider organizations of different compositions,
4315 including, but not limited to, physician group entities and independent physician organizations,
4316 to successfully apply for certification.

4317 (e) Provider organizations shall annually renew their certification as a Beacon ACO.
4318 Failure to meet the requirements represented in the certification may result in decertification, as
4319 determined by the board.

4320 Section 9. (a) The authority, in consultation with the advisory board, shall develop best
4321 practices and standards for alternative payment methodologies for use by the group insurance
4322 commission, the office of Medicaid and any other state funded insurance program. Any
4323 alternative payment methodology shall: (1) support the state's efforts to meet the health care cost
4324 benchmark established in section 5; (2) include incentives for higher quality care; (3) include a
4325 risk adjustment element based on health status; and (4) to the extent possible, include a risk
4326 adjustment element that takes into account functional status, socioeconomic status or cultural
4327 factors. The authority shall also consider methodologies to account for the following costs: (i)
4328 medical education; (ii) stand-by services and emergency services, including, but not limited to,
4329 trauma units and burn units; (iii) services provided by disproportionate share hospitals or other
4330 providers serving underserved populations; (iv) services provided to children; (v) research; (vi)
4331 care coordination and community based services provided by allied health professionals; (vii) the
4332 greater integration of behavioral and mental health; and (viii) the use and the continued
4333 advancement of new medical technologies, treatments, diagnostics or pharmacology products

4334 that offer substantial clinical improvements and represent a higher cost than the use of current
4335 therapies.

4336 Any best practices and standards developed under this section shall be shared with all
4337 private health plans for their voluntary adoption.

4338 Section 10. (a) The authority, in consultation with the advisory board, shall administer the
4339 Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of
4340 2011. The fund shall be used for the following purposes: (1) to support the activities of the
4341 authority; and (2) to foster innovation in payment and health care service delivery.

4342 (b) The authority shall establish a competitive process for health care entities to develop,
4343 implement, or evaluate promising models in payment and health care service delivery.
4344 Assistance from the authority may take the form of incentives, grants, technical assistance,
4345 evaluation assistance or partnerships, as determined by the authority.

4346 (c) Prior to making a request for proposals under subsection (b), the authority shall solicit
4347 ideas for payment changes and health care delivery service reforms directly from providers,
4348 provider organizations, carriers, research institutions, health professionals, public institutions of
4349 higher education, community-based organizations and private-public partnerships, or any
4350 combination thereof. The authority shall review payment and service delivery models so
4351 submitted and shall seek input from other relevant stakeholders in evaluating their potential.

4352 (d) All approved activities funded through the Healthcare Payment Reform Fund shall
4353 support the commonwealth's efforts to meet the health care cost growth benchmark established
4354 under section 5, and shall include measurable outcomes in both cost reduction and quality
4355 improvement.

4356 (e) To the maximum extent feasible, the authority shall seek to coordinate expenditures
4357 from the Healthcare Payment Reform Fund with other public expenditures from the Prevention
4358 and Wellness Trust Fund, the e-Health Institute Trust Fund, the Health Care Workforce
4359 Transformation Trust Fund, the executive office of health and human services and any funding
4360 available through the Medicare program and the CMS Innovation Center, established under the
4361 federal Patient Protection and Affordable Care Act.

4362 (f) Activities funded through the Healthcare Payment Reform Fund which demonstrates
4363 measurable success in improving care or reducing costs shall be shared with other providers,
4364 provider organizations and payers as model programs which may be voluntarily adopted by such
4365 other health care entities. The authority may also incorporate any successful models and
4366 practices into its standards for the Beacon ACO certification under section 8 and for alternative
4367 payment methodologies established for state-funded programs under section 9.

4368 (g) The authority shall, annually on or before January 31, report on expenditures from the
4369 Healthcare Payment Reform Fund. The report shall include, but not be limited to: (i) the revenue
4370 credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs
4371 of the authority; (iii) an itemized list of the funds expended through the competitive process and
4372 a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of
4373 the activities funded through grants. The report shall be provided to the chairs of the house and
4374 senate committees on ways and means and the joint committee on health care financing and shall
4375 be posted on the authority's website.

4376 Section 11. (a) All expenses incurred in carrying out this chapter shall be payable solely
4377 from funds provided under the authority of this chapter and no liability or obligations shall be

4378 incurred by the authority under this chapter beyond the extent to which monies shall have been
4379 provided under this chapter.

4380 (b) The authority shall be liable on all claims made as a result of the activities, whether
4381 ministerial or discretionary, of any member, officer or employee of the authority acting as such,
4382 except for willful dishonesty or intentional violation of the law, in the same manner and to the
4383 same extent as a private person under like circumstances; provided, however, that the authority
4384 shall not be liable to levy or execution on any real or personal property to satisfy judgment, for
4385 interest prior to judgment, for punitive damages or for any amount in excess of \$100,000.

4386 (c) No person shall be liable to the commonwealth, to the authority or to any other person
4387 as a result of the person's activities, whether ministerial or discretionary, as a member, officer or
4388 employee of the authority except for willful dishonesty or intentional violation of the law;
4389 provided, however, that such person shall provide reasonable cooperation to the authority in the
4390 defense of any claim. Failure of such person to provide reasonable cooperation shall cause such
4391 person to be jointly liable with the authority, to the extent that such failure prejudiced the defense
4392 of the action.

4393 (d) The authority may indemnify or reimburse any person, or a person's personal
4394 representative, for losses or expenses, including legal fees and costs, arising from any claim,
4395 action, proceeding, award, compromise, settlement or judgment resulting from such person's
4396 activities, whether ministerial or discretionary, as a member, officer or employee of the
4397 authority; provided, that the defense of settlement thereof shall have been made by counsel
4398 approved by the authority. The authority may procure insurance for itself and for its members,

4399 officers and employees against liabilities, losses and expenses which may be incurred by virtue
4400 of this section or otherwise.

4401 (e) No civil action under this chapter shall be brought more than 3 years after the date
4402 upon which the cause thereof accrued.

4403 (f) Upon dissolution, liquidation or other termination of the authority, all rights and
4404 properties of the authority shall pass to and be vested in the commonwealth, subject to the rights
4405 of lien holders and other creditors. In addition, any net earnings of the authority, beyond that
4406 necessary for retirement of any indebtedness or to implement the public purpose or purposes or
4407 program of the commonwealth, shall not inure to the benefit of any person other than the
4408 commonwealth.

4409 Section 12. The authority shall keep an accurate account of all its activities and of all its
4410 receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year
4411 to its board, to the governor, to the general court and to the state auditor, such reports to be in a
4412 form prescribed by the board, with the written approval of the auditor. The board or the auditor
4413 may investigate the affairs of the authority, may severally examine the properties and records of
4414 the authority and may prescribe methods of accounting and the rendering of periodical reports in
4415 relation to projects undertaken by the authority. The authority shall be subject to biennial audit
4416 by the state auditor.

4417 Section 13. The authority may adopt regulations to implement this chapter.

4418 CHAPTER 176T

4419 CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

4420 Section 1. As used in this chapter, the following words shall, unless the context clearly
4421 requires otherwise, have the following meanings:

4422 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health
4423 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
4424 176A; a nonprofit medical service corporation organized under chapter 176B; a health
4425 maintenance organization organized under chapter 176G; an organization entering into a
4426 preferred provider arrangement under chapter 176I; a contributory group general or blanket
4427 insurance for persons in the service of the commonwealth under chapter 32A; a contributory
4428 group general or blanket insurance for persons in the service of counties, cities, towns and
4429 districts and their dependents under chapter 32B; the medical assistance program administered
4430 by the office of Medicaid under chapter 118E and under Title XIX of the Social Security Act or
4431 any successor statute; and any other medical assistance program operated by a governmental unit
4432 for persons categorically eligible for such program.

4433 “Commissioner”, the commissioner of insurance.

4434 “Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a
4435 carrier.

4436 “Nondiscriminatory basis”, a carrier shall be providing coverage on a non-discriminatory
4437 basis if its plan does not contain any annual or lifetime dollar or unit of service limitation
4438 imposed on coverage for the care provided by a physician assistant which is less than any annual
4439 or lifetime dollar or unit of service limitation imposed on coverage for the same services by other
4440 participating providers.

4441 “Participating provider”, a provider who, under terms and conditions of a contract with
4442 the carrier or with its contractor or subcontractor, has agreed to provide health care services to an
4443 insured with an expectation of receiving payment, other than coinsurance, co-payments or
4444 deductibles, directly or indirectly, from the carrier.

4445 “Physician assistant”, a person who is a graduate of an approved program for the training
4446 of physician assistants who is supervised by a registered physician under sections 9C to 9H,
4447 inclusive, of chapter 112, and who has passed the Physician Assistant National Certifying Exam
4448 or its equivalent.

4449 “Primary care provider”, a health care professional qualified to provide general medical
4450 care for common health care problems who (i) supervises, coordinates, prescribes or otherwise
4451 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
4452 maintains continuity of care within the scope of practice.

4453 Section 2. The commissioner and the group insurance commission shall require that all
4454 carriers recognize physician assistants as participating providers subject to section 3 and shall
4455 include coverage on a nondiscriminatory basis to their insureds for care provided by physician
4456 assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall
4457 include benefits for primary care, intermediate care and inpatient care, including care provided in
4458 a hospital, clinic, professional office, home care setting, long-term care setting, mental health or
4459 substance abuse program, or any other setting when rendered by a physician assistant who is a
4460 participating provider and is practicing within the scope of the physician assistant’s professional
4461 authority as defined by statute, rule and physician delegation to the extent that such policy or

4462 contract currently provides benefits for identical services rendered by a provider of health care
4463 licensed by the commonwealth.

4464 Section 3. A participating provider physician assistant practicing within the scope of the
4465 physician assistant’s license, including all regulations requiring collaboration with or supervision
4466 by a physician under section 9E of chapter 112, shall be considered qualified within the carrier’s
4467 definition of primary care provider to an insured.

4468 Section 4. Notwithstanding any general or special law to the contrary, a carrier that
4469 requires the designation of a primary care provider shall provide its insured with an opportunity
4470 to select a participating provider physician assistant as a primary care provider.

4471 Section 5. Notwithstanding any general or special law to the contrary, a carrier shall
4472 ensure that all participating provider physician assistants are included on any publicly accessible
4473 list of participating providers for the carrier.

4474 Section 6. A complaint for noncompliance against a carrier shall be filed with and
4475 investigated by the commissioner or the group insurance commission, whichever shall have
4476 regulatory authority over the carrier. The commissioner and the group insurance commission
4477 shall promulgate regulations to implement this chapter.

4478 SECTION 163. Clause (5) of subsection (d) of section 8A of chapter 180 of the General
4479 Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 100
4480 and 101, the words “division of health care finance and policy pursuant to chapter 118G” and
4481 inserting in place thereof the following words:- institute of health care finance and policy under
4482 chapter 12C.

4483 SECTION 164. Subsection (a) of section 9 of chapter 209C of the General Laws, as so
4484 appearing, is hereby amended by striking out, in lines 36 and 37, the words “the division of
4485 medical assistance or division of health care finance and policy” and inserting in place thereof
4486 the following words:- the office of Medicaid or the executive office of health and human
4487 services.

4488 SECTION 165. Section 60K of chapter 231 of the General Laws, as so appearing, is
4489 hereby amended by striking out, in line 14, the figure “4” and inserting in place thereof the
4490 following figure:- 2.

4491 SECTION 166. Said chapter 231 is hereby amended by inserting after section 60K, the
4492 following 3 sections:-

4493 Section 60L. (a) Except as provided in this section, a person shall not commence an
4494 action against a provider of health care as defined in the seventh paragraph of section 60B unless
4495 the person has given the health care provider written notice under this section of not less than
4496 182 days before the action is commenced.

4497 (b) The notice of intent to file a claim required under subsection (a) shall be mailed to the
4498 last known professional business address or residential address of the health care provider who is
4499 the subject of the claim.

4500 (c) The 182 day notice period in subsection (a) shall be shortened to 90 days if:

4501 (1) the claimant has previously filed the 182 day notice required against another
4502 health care provider involved in the claim; or

4503 (2) the claimant has filed a complaint and commenced an action alleging medical
4504 malpractice against 1 or more of the health care providers involved in the claim.

4505 (d) The 182 day notice of intent required in subsection (a) shall not be required if the
4506 claimant did not identify and could not reasonably have identified a health care provider to
4507 which notice shall be sent as a potential party to the action before filing the complaint;

4508 (e) The notice given to a health care provider under this section shall contain, but need
4509 not be limited to, a statement including:

4510 (1) the factual basis for the claim;

4511 (2) the applicable standard of care alleged by the claimant;

4512 (3) the manner in which it is claimed that the applicable standard of care was
4513 breached by the health care provider;

4514 (4) the alleged action that should have been taken to achieve compliance with the
4515 alleged standard of care;

4516 (5) the manner in which it is alleged the breach of the standard of care was the
4517 proximate cause of the injury claimed in the notice; and

4518 (6) the names of all health care providers that the claimant is notifying under this
4519 section in relation to a claim.

4520 (f) Not later than 56 days after giving notice under this section, the claimant shall allow
4521 the health care provider receiving the notice access to all of the medical records related to the
4522 claim that are in the claimant's control and shall furnish release for any medical records related

4523 to the claim that are not in the claimant's control, but of which the claimant has knowledge.

4524 This subsection shall not restrict a patient's right of access to the patient's medical records under
4525 any other law.

4526 (g) Within 150 days after receipt of notice under this section, the health care provider or
4527 authorized representative against whom the claim is made shall furnish to the claimant or the
4528 claimant's authorized representative a written response that contains a statement including the
4529 following:

4530 (1) the factual basis for the defense, if any, to the claim;

4531 (2) the standard of care that the health care provider claims to be applicable to the
4532 action;

4533 (3) the manner in which it is claimed by the health care provider that there was or
4534 was not compliance with the applicable standard of care; and

4535 (4) the manner in which the health care provider contends that the alleged
4536 negligence of the health care provider was or was not a proximate cause of the claimant's alleged
4537 injury or alleged damage.

4538 (h) If the claimant does not receive the written response required under subsection (g)
4539 within the required 150 day time period, the claimant may commence an action alleging medical
4540 malpractice upon the expiration of the 150 day time period. If a provider fails to respond within
4541 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other
4542 means then interest on any judgment against that provider shall accrue and be calculated from
4543 the date that the notice was filed rather than the date that the suit is filed. At any time before the

4544 expiration of the 150 day period, the claimant and the provider may agree to an extension of the
4545 150 day period.

4546 (i) If at any time during the applicable notice period under this section a health care
4547 provider receiving notice under this section informs the claimant in writing that the health care
4548 provider does not intend to settle the claim within the applicable notice period, the claimant may
4549 commence an action alleging medical malpractice against the health care provider, so long as the
4550 claim is not barred by the statute of limitations or repose.

4551 (j) A lawsuit against a health care provider filed within 6 months of the statute of
4552 limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any
4553 claimant, shall be exempt from compliance with this section.

4554 (k) Nothing in this section shall prohibit the filing of suit at any time in order to seek
4555 court orders to preserve and permit inspection of tangible evidence.

4556 Section 60M. In any action for malpractice, negligence, error, omission, mistake or the
4557 unauthorized rendering of professional services against a provider licensed under section 2 of
4558 chapter 112, including actions under section 60B, an expert witness shall have been engaged in
4559 the practice of medicine at the time of the alleged wrongdoing.

4560 Section 60N. In any action for malpractice, negligence, error, omission, mistake or the
4561 unauthorized rendering of professional services against a provider licensed under section 2 of
4562 chapter 112, including actions under section 60B, an expert witness shall be board certified in the
4563 same specialty as the defendant physician as licensed under section 2 of chapter 112.

4564 SECTION 167. Section 85K of said chapter 231, as appearing in the 2010 Official
4565 Edition, is hereby amended by inserting, in line 8, after the word “costs”, the following words:-
4566 ; provided, however, in the context of medical malpractice claims against a non-profit
4567 charity providing health care, such cause of action shall not exceed the sum of \$100,000,
4568 exclusive of interest and costs.

4569 SECTION 168. Chapter 233 of the General Laws is hereby amended by inserting after
4570 section 79K, the following new section:-

4571 Section 79L. (a) As used in this section, the following words shall, unless the context
4572 clearly requires otherwise, have the following meanings:

4573 “Facility”, a hospital, clinic, or nursing home licensed under chapter 111 or a home
4574 health agency; provided, that “facility” shall also include any corporation, professional
4575 corporation, partnership, limited liability company, limited liability partnership, authority or
4576 other entity comprised of such facilities.

4577 “Health care provider”, any of the following health care professionals licensed under
4578 chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist,
4579 optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social
4580 worker, speech-language pathologist, audiologist, marriage and family therapist or mental health
4581 counselor; provided, that “health care provider” shall also include any corporation, professional
4582 corporation, partnership, limited liability company, limited liability partnership, authority, or
4583 other entity comprised of such health care providers.

4584 “Unanticipated outcome”, the outcome of a medical treatment or procedure, whether or
4585 not resulting from an intentional act, that differs from an intended result of such medical
4586 treatment or procedure.

4587 (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly
4588 experiencing an unanticipated outcome of medical care, any and all statements, affirmations,
4589 gestures, activities or conduct expressing benevolence, regret, apology, sympathy,
4590 commiseration, condolence, compassion, mistake, error or a general sense of concern which are
4591 made by a health care provider, facility or an employee or agent of a health care provider or
4592 facility, to the patient, a relative of the patient or a representative of the patient and which relate
4593 to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative
4594 proceeding, unless the maker of the statement, or a defense expert witness, when questioned
4595 under oath during the litigation about facts and opinions regarding any mistakes or errors that
4596 occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in
4597 which case the statements and opinions made about the mistake or error shall be admissible for
4598 all purposes. In situations where a patient suffers an unanticipated outcome with significant
4599 medical complication resulting from the provider’s mistake, the health care provider, facility or
4600 an employee or agent of a health care provider or facility shall fully inform the patient, and when
4601 appropriate the patient's family, about said unanticipated outcome.

4602 SECTION 169. Clause (2) of subsection (b) of section 3 of chapter 258C of the General
4603 Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out sub-clause
4604 (A) and inserting in place thereof the following sub-clause:- (A) Expenses incurred for hospital
4605 services as the direct result of injury to the victim shall be compensable under this chapter;
4606 provided, however, that when claiming compensation for hospital expenses, the claimant shall

4607 demonstrate an out-of-pocket loss or a legal liability for payment of said expenses. No hospital
4608 expenses shall be paid if the expense is reimbursable by Medicaid or if the services are covered
4609 by chapter 118E. Every claim for compensation for hospital services shall include a certification
4610 by the hospital that the services are not reimbursable by Medicaid and that the services are not
4611 covered by chapter 118E. In no event shall the amounts awarded for hospital services exceed the
4612 rates for services established by the executive office of health and human services or a
4613 governmental unit designated by the executive office if rates have been established for such
4614 services.

4615 SECTION 170. The second paragraph of section 4 of chapter 260 of the General Laws,
4616 as so appearing, is hereby amended by adding the following sentence:-

4617 The statutes of limitation and repose in this paragraph shall be tolled for a period of 180
4618 days when a notice of intent to file a claim, under subsection (a) of section 60L of chapter 231, is
4619 sent to a provider of health care as defined in the seventh paragraph of section 60B of chapter
4620 231.

4621 SECTION 171. Section 15 of chapter 305 of the acts of 2008 is hereby repealed.

4622 SECTION 172. Chapter 288 of the acts of 2010 is hereby amended by striking out
4623 section 66 and inserting in place thereof the following section:-

4624 SECTION 66. For small group base rate factors applied under section 3 of chapter 176J
4625 of the General Laws between October 1, 2010 and July 1, 2015, a carrier shall limit the effect of
4626 the application of any single or combination of rate adjustment factors identified in paragraphs
4627 (2) to (6), inclusive, of subsection (a) of said chapter 3 of said chapter 176J that are used in the
4628 calculation of an individual's or small group's premium so that the final annual premium charged

4629 to an individual or small group does not increase by more than an amount established annually
4630 by the commissioner by regulation.

4631 SECTION 173. Section 70 of said chapter 288 is hereby amended by striking out the
4632 figure “2012” and inserting in place thereof the following figure:- 2015.

4633 SECTION 174. Notwithstanding any general or special law to the contrary, the
4634 commissioner of public health, in consultation with the board of registration in medicine, shall
4635 promulgate regulations on or before April 1, 2013 to enforce section 226 of chapter 111 of the
4636 General Laws.

4637 SECTION 175. Notwithstanding any general or special law to the contrary, the
4638 department of public health, in consultation with the division of insurance, shall examine and
4639 study best practices and successful models of private sector wellness and health management
4640 programs in order to create a model wellness guide for payers, employers and consumers. The
4641 department shall also issue a report that identifies those elements of said programs that should be
4642 promoted in support of the state’s efforts to meet the health care cost growth benchmark
4643 established under section 5 of chapter 176S.

4644 The model guide shall provide the following information: (i) the importance of healthy
4645 lifestyles, disease prevention, care management and health promotion programs; (ii) financial
4646 and other incentives for brokers, payers and consumers to encourage health and wellness
4647 program offerings for consumers and to expand options for individuals who do not have access
4648 to these programs through their workplace; (iii) benefit designs that tie financial consequences to
4649 health care choices; (iv) use of technology to provide wellness information and services; and (v)

4650 identifying qualitative and quantitative program measures to place real value on program results
4651 and track program effectiveness.

4652 In developing the report and model guide, the secretary shall consult with health care
4653 stakeholders, including but not limited to: employers, including representatives of employers
4654 with more than 50 employees and representatives of employers with less than 50 employees;
4655 providers and provider organizations; health carriers; and consumers. The report, along with any
4656 recommendations, shall be submitted to the joint committee on health care financing, the house
4657 and senate committees on ways and means and the secretary of health and human services by
4658 January 1, 2013. The recommendations shall assist in the development of strategies and
4659 programs supported by the Prevention and Wellness Trust Fund established under section 2G of
4660 chapter 111 of the General Laws.

4661 SECTION 176. Notwithstanding any general or special law or rule or regulation to the
4662 contrary, the commissioner of insurance shall promulgate regulations requiring any carrier, as
4663 defined in section 1 of chapter 176O of the General Laws, and their contractors to comply with
4664 and implement the federal Mental Health Parity and Addiction Equity Act of 2008, section 511
4665 of Public Law 110-343. The commissioner of insurance shall promulgate said regulations not
4666 later than January 1, 2013. The regulations shall be implemented as part of any provider
4667 contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed
4668 or amended on or after July 31, 2012.

4669 Starting on July 1, 2013, the commissioner of insurance shall require all carriers and their
4670 contractors, to submit an annual report to the division of insurance, which shall be a public
4671 record, certifying and outlining how their health benefit plans are in compliance with the federal

4672 Mental Health Parity and Addiction Equity Act and this section. The division of insurance shall
4673 forward all such reports to the attorney general for verification of compliance with the federal
4674 Mental Health Parity and Addiction Equity Act and this section.

4675 SECTION 177. Notwithstanding any general or special law or rule or regulation to the
4676 contrary, the office of Medicaid shall promulgate regulations requiring any Medicaid health plan
4677 and managed care organization and their health plans and any behavioral health management
4678 firm and third party administrator under contract with a Medicaid managed care organization to
4679 comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008,
4680 section 511 of Public Law 110-343. The office of Medicaid shall promulgate said regulations
4681 not later than January 1, 2013. The regulations shall be implemented as part of any provider
4682 contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed
4683 or amended on or July 31, 2012.

4684 Starting on July 1, 2013, the office of Medicaid shall submit an annual report to the house
4685 and senate chairs of the joint committee on health care financing, the house and senate chairs of
4686 the joint committee on mental health and substance abuse, the clerk of the senate and the clerk of
4687 the house of representatives certifying and outlining how the health benefit plans under the office
4688 of Medicaid, and any contractors, are in compliance with the federal Mental Health Parity and
4689 Addiction Equity Act and this section. The office of Medicaid shall forward all such reports to
4690 the department of the attorney general for verification of compliance with the federal Mental
4691 Health Parity and Addiction Equity Act and this section.

4692 SECTION 178. Notwithstanding any general or special law to the contrary, the board of
4693 registration of medicine, established under section 10 of chapter 13 of the General Laws, shall

4694 promulgate regulations relative to the education and training of health care providers in the early
4695 disclosure of adverse events, including, but not limited to, continuing medical education
4696 requirements. Nothing in this section shall affect the total hours of continuing medical education
4697 required by the board, including the number of hours required relative to risk management.

4698 SECTION 179. Notwithstanding any general or special law to the contrary, the
4699 department of public health, in consultation with the Betsy Lehman center for patient safety and
4700 medical error reduction, established under section 16E of chapter 6A of the General Laws, shall
4701 create an independent task force to study and reduce the practice of defensive medicine and
4702 medical overutilization in the commonwealth, including but not limited to the overuse of
4703 imaging and screening technologies. At least 1 member of the task force shall be a health care
4704 consumer representative. The task force shall issue a report on the financial and non-financial
4705 impacts of defensive medicine and the impact of overutilization on patient safety. The task force
4706 shall file a report of its study, including its recommendations and drafts of any legislation, if
4707 necessary, by filing the same with the clerks of the senate and house of representatives who shall
4708 forward a copy of the report to the joint committee on public health and the joint committee on
4709 health care financing within 1 year of the effective date of this act.

4710 SECTION 180. Notwithstanding any general or special law to the contrary, to the extent
4711 that the office of Medicaid, the group insurance commission, the commonwealth health
4712 insurance connector authority and any other state funded insurance program determine that
4713 accountable care organizations offer opportunities for cost-effective and high quality care, such
4714 state funded insurance programs shall prioritize provider organizations which have been certified
4715 by the board of the health care quality and finance authority as Beacon ACOs, under section 8 of
4716 chapter 176S, for the delivery of publicly funded health services.

4717 SECTION 181. Any provider organization that entered a network contract prior to the
4718 effective date of chapter 12C of the General Laws, which organization receives, or represents
4719 providers who collectively receive, at least \$10,000,000 in annual net patient service revenue
4720 from carriers or third-party administrators or which has entered full-risk contracts or which is
4721 corporately affiliated with a carrier, shall register under section 10 of said chapter 12C not later
4722 than December 1, 2012. Any other provider organization that entered a network contract prior to
4723 the effective date of said chapter 12C and is required under said section 10 of said chapter 12C to
4724 register shall register not later than December 1, 2013.

4725 Notwithstanding any other provision of said chapter 12C, and as a condition of licensure
4726 under chapter 111 of the General Laws, any provider that is part of or represented by a provider
4727 organization that entered a network contract and fails to register under said section 10 of said
4728 chapter 12C shall continue to deliver care under such network contract for the duration of such
4729 contract, or a period of 5 years, whichever is longer, at the contract terms and payment levels in
4730 effect upon the date the provider organization fails to register under said section 10 of said
4731 chapter 12C.

4732 SECTION 182. There shall be a task force comprised of 9 representatives with expertise
4733 in behavioral health treatment, service delivery, integration of behavioral health with primary
4734 care and behavioral health reimbursement systems. The health care quality and finance authority
4735 shall appoint the members of the task force. The task force shall report to the authority its
4736 findings and recommendations relative to: (i) the most effective and appropriate approach to
4737 including behavioral health services in the array of services provided by integrated provider
4738 organizations; (ii) how current prevailing reimbursement methods and covered behavioral health
4739 benefits may need to be modified to achieve more cost effective, integrated and high quality

4740 behavioral health outcomes; and (iii) the extent to which and how payment for behavioral health
4741 services should be included under alternative payment methods. The task force shall submit its
4742 report of findings and recommendations to the authority not later than July1, 2013.

4743 SECTION 183. Notwithstanding any general or special law to the contrary, the
4744 department of public health shall submit a health resource plan to the governor and the general
4745 court, as required by section 25A of chapter 111 of the General Laws, not later than January 1,
4746 2014.

4747 SECTION 184. Notwithstanding any general or special law to the contrary, there shall be
4748 a special task force, to study issues related to the accuracy of medical diagnosis in the
4749 commonwealth, called the Massachusetts Diagnostic Accuracy Task Force. The task force shall
4750 investigate and report on: the extent to which diagnoses in the commonwealth are accurate and
4751 reliable; the underlying systematic causes of inaccurate diagnosis; estimation of the financial cost
4752 to the state, insurers and employers of inaccurate diagnoses; the negative impact on patients
4753 caused by inaccurate diagnoses; and recommendations to reduce or eliminate the impact of
4754 inaccurate diagnoses.

4755 The Massachusetts Diagnostic Accuracy Task Force shall be comprised of 9 members,
4756 including the commissioner of public health, or a designee, who shall act as the chair; and 8
4757 members, who shall be appointed by the commissioner of public health, who shall reflect a broad
4758 distribution of diverse perspectives on the health care system, including health care
4759 professionals, consumer representatives, provider organizations and payers.

4760 The task force shall file a report of its study, including its recommendations and drafts of
4761 any legislation, if necessary, with the clerks of the senate and house of representatives within 1
4762 year of the effective date of this act.

4763 SECTION 185. Notwithstanding any general or special law to the contrary, the institute
4764 of health care finance and policy shall, in consultation with the executive office of health and
4765 human services, the department of public health, the office of Medicaid and the division of
4766 insurance, review existing reporting and data collection requirements for health care providers,
4767 provider organizations and payers. The institute shall identify reporting and data collection
4768 requirements that are unnecessary, duplicative, which could be combined or which should be
4769 transferred to the institute in its role as the primary health care data repository for the
4770 commonwealth.

4771 The institute shall file the results of its review, together with drafts of legislation, if any,
4772 necessary to carry out its recommendations, by filing the same with the clerks of the house of
4773 representatives and the senate who shall forward a copy of the study to the house and senate
4774 committees on ways and means and the joint committee on health care financing not later than
4775 January 1, 2014.

4776 SECTION 186. Notwithstanding any general or special law to the contrary, beginning not
4777 later than July 1, 2014, the group insurance commission, MassHealth and any other state funded
4778 insurance program shall, to the maximum extent feasible, implement alternative payment
4779 methodologies, as defined in section 1 of chapter 12C. The alternative payment methodologies
4780 shall be developed in consultation with the health care quality and finance authority under

4781 section 8 of chapter 176S and all affected publically funded health plans, including, but not
4782 limited to, the Medicaid managed care organizations.

4783 SECTION 187. Notwithstanding any general or special law to the contrary, the health
4784 care quality and finance authority shall contract with an independent outside organization to
4785 conduct a comprehensive review of the impact of this act, and transformations in the health care
4786 payment system and care delivery system in the commonwealth, on health care consumers, the
4787 health care workforce and the general public.

4788 The review shall include, but not be limited to, an investigation of:

4789 (1) The impact on health care costs, including the extent to which savings have
4790 reduced out-of-pocket costs to individuals and families, health insurance premium costs and
4791 health care costs borne by the commonwealth;

4792 (2) The impact on access to health care services and quality of care in different
4793 regions and for different populations, particularly for children, the elderly, low-income
4794 individuals, individuals with disabilities and other vulnerable populations;

4795 (3) The impact on access and quality of care for specific services, particularly
4796 primary care, behavioral and mental health services;

4797 (4) The impact on the health care workforce, including, but not limited to, health
4798 care worker recruitment and retention, health care worker shortages, training and education
4799 requirements and job satisfaction; and

4800 (5) The impact on public health, including, but not limited to, reducing the
4801 prevalence of preventable health conditions, improving employee wellness and reducing racial
4802 and ethnic disparities in health outcomes.

4803 The organization shall, to the extent possible, obtain and use data from the institute of
4804 health care finance and policy to conduct its analysis; provided, however, that such data shall be
4805 confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4
4806 of the General Laws.

4807 The health care quality and finance authority shall report the results of such review and
4808 its recommendations, if any, together with drafts of legislation necessary to carry out such
4809 recommendations to the house and senate committees on ways and means, the joint committee
4810 on public health and post the results on the health care quality and finance authority's website
4811 not later than March 31, 2017.

4812 SECTION 188. Notwithstanding any general or special law or rule or regulation to the
4813 contrary, upon the adoption of national electronic prior authorization standards by the National
4814 Council for Prescription Drug Programs, the e-Health Institute shall prepare a report that
4815 identifies the appropriate administrative regulations of the commonwealth that will need to be
4816 promulgated in order to make those standards effective within 12 months of adoption of said
4817 standards by the National Council for Prescription Drug Programs. The institute shall, not later
4818 than 6 months after the adoption of such standards by the National Council for Prescription Drug
4819 Programs, submit its report together with any further recommendations and draft legislative
4820 language necessary to carry out its recommendations to the joint committee on public health, the
4821 joint committee on health care financing and the governor.

4822 SECTION 189. There shall be a special commission to review public payer
4823 reimbursement rates and payment systems for health care services and the impact of such rates
4824 and payment systems on health care providers and on health insurance premiums in the
4825 commonwealth. The commission shall consist of 11 members: 1 of whom shall be the secretary
4826 of health and human services or a designee, who shall serve as chair; 1 of whom shall be the
4827 director of the office of Medicaid; 1 of whom shall be the executive director of the institute of
4828 health care finance and policy; 1 of whom shall be appointed by the Massachusetts Hospital
4829 Association; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom
4830 shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed
4831 by the Home Care Alliance of Massachusetts; 1 of whom shall be appointed by the
4832 Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the
4833 Massachusetts Association for Behavioral Healthcare; and 2 of whom shall be appointed by the
4834 governor, 1 of whom shall be represent managed care organizations contracting with MassHealth
4835 and 1 of whom shall be an expert in medical payment methodologies from a foundation or
4836 academic institution.

4837 The commission shall examine whether public payer rates and rate methodologies
4838 provide fair compensation for health care services and promote high-quality, safe, effective,
4839 timely, efficient, culturally competent and patient-centered care. The commission's analysis
4840 shall include, but not be limited to, an examination of MassHealth rates and rate methodologies;
4841 current and projected federal financing, including Medicare rates; cost-shifting and the interplay
4842 between public payer reimbursement rates and health insurance premiums; and the degree to
4843 which public payer rates reflect the actual cost of care.

4844 To conduct its review and analysis, the commission may contract with an outside
4845 organization with expertise in the analysis of health care financing. The institute of health care
4846 finance and policy and the office of Medicaid shall provide the outside organization, to the extent
4847 possible, with any relevant data necessary for the evaluation; provided, however, that such data
4848 shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of
4849 chapter 4 of the General Laws.

4850 The commission shall file the results of its study, together with drafts of legislation, if
4851 any, necessary to carry out its recommendations, by filing the same with the clerks of the house
4852 of representatives and the senate who shall forward a copy of the study to the house and senate
4853 committees on ways and means and the joint committee on health care financing not later than
4854 April 1, 2013.

4855 SECTION 190. There shall be a special commission to review variation in prices among
4856 providers. The commission shall consist of 14 members: 1 of whom shall be the executive
4857 director of the institute of health care finance and policy or a designee, who shall serve as chair;
4858 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be
4859 the executive director of the group insurance commission or a designee; 1 of whom shall be the
4860 secretary of health and human services or a designee; 1 of whom shall be the attorney general or
4861 a designee; 4 of whom shall be appointed by the governor, 1 of whom shall be a health
4862 economist, 1 of whom shall have expertise in the area of health care payment methodology, 1 of
4863 whom shall represent non-physician health care providers and 1 of whom shall represent an
4864 academic medical center or teaching hospital; 1 of whom shall be appointed by the senate
4865 president and shall be a health economist or have expertise in the area of health care payment
4866 methodology; 1 of whom shall be appointed by the speaker of the house of representatives and

4867 shall be a health economist or have expertise in the area of health care payment methodology; 1
4868 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc.; 1 of
4869 whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom
4870 shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall be
4871 a representative of the Massachusetts Medical Society.

4872 The commission shall conduct a rigorous analysis to identify the acceptable and
4873 unacceptable factors contributing to price variation in physician, hospitals, diagnostic testing and
4874 ancillary services. The analysis shall include, but not be limited to, an examination of the
4875 following factors: quality, medical education, stand-by service capacity, emergency service
4876 capacity, special services provided by disproportionate share hospitals and other providers
4877 serving underserved or unique populations, market share, advertising, location, research, costs,
4878 care coordination, community-based services provided by allied health professionals and use of
4879 and continued advancement of medical technology and pharmacology. The analysis shall also
4880 include a comparison of price variation between providers in the commonwealth and providers in
4881 other states.

4882 After identifying such factors, the commission shall recommend steps to reduce provider
4883 price variation and shall recommend the maximum reasonable adjustment to a commercial
4884 insurer's median rate for individual or groupings of services for each acceptable factor.

4885 To conduct its review and analysis, the commission may contract with an outside
4886 organization with expertise in the analysis of health care financing and provider payment
4887 methodologies. The institute of health care finance and policy shall provide the commission and
4888 any contracted outside organization, to the extent possible, relevant data necessary for the

4889 evaluation; provided, however, that such data shall be confidential and shall not be a public
4890 record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

4891 The commission shall file the results of its study, together with drafts of legislation, if
4892 any, necessary to carry out its recommendations, by filing the same with the clerks of the house
4893 of representatives and the senate who shall forward a copy of the study to the house and senate
4894 committees on ways and means and the joint committee on health care financing not later than
4895 January 1, 2014.

4896 SECTION 191. (a) There shall be an e-Health commission which shall evaluate the
4897 effectiveness of expenditures authorized under section 6D of chapter 40J of the General Laws.
4898 The commission shall consist of 17 members: 1 of whom shall be the secretary of administration
4899 and finance or a designee, who shall serve as chair; 1 of whom shall be the secretary of health
4900 and human services or a designee; 1 of whom shall be the executive director of the institute of
4901 health care finance and policy or a designee; 1 of whom shall be the secretary of housing and
4902 economic development or a designee; 1 of whom shall be the senate chair of the joint committee
4903 on health care financing; 1 of whom shall be the house chair of the joint committee on health
4904 care financing; 11 of whom shall be appointed by the governor, 1 of whom shall be an expert in
4905 health information technology, 1 of whom shall be an expert in state and federal health privacy
4906 laws, 1 of whom shall be an expert in health policy, 1 of whom shall be an expert in health
4907 information technology relative to privacy and security, 1 of whom shall be from an academic
4908 medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a
4909 community health center, 1 of whom shall be from a long term care facility, 1 of whom shall be
4910 from a physician group practice and 2 of whom shall represent health insurance carriers.

4911 (b) The commission shall review the Massachusetts e-Health Institute, including an
4912 analysis of all relevant data so as to determine the effectiveness and return on investment of
4913 funding under said section 6D of said chapter 40J. The report shall include specific legislative
4914 recommendations including the following:-

4915 (1) to what extent the program increased the adoption of interoperable electronic
4916 health records, including to what extent the program increased the adoption of interoperable
4917 electronic health records for providers;

4918 (2) to what extent the program reduced health care costs or the growth in health
4919 care cost trends on a provider-based net cost and health plan based premium basis, including an
4920 analysis of what entities benefitted or were disadvantaged from any cost reductions and the
4921 specific impact of the funding mechanism as established in subsection (a) of section 70 of
4922 chapter 118E;

4923 (3) to what extent the program increased the number of health care providers in
4924 achieving and maintaining compliance with the standards for meaningful use, beyond stage 1,
4925 established by the United States Department of Health and Human Services ;

4926 (4) to what extent the program should be discontinued, amended or expanded, and
4927 if so, a timetable for implementation of the recommendations; and

4928 (5) to what extent additional public funding is needed for the e-Health Institute
4929 Fund, as established in section 6E of chapter 40J of the General Laws.

4930 (c) To conduct these studies, the commission shall contract with an outside organization
4931 with expertise in the analysis of the health care financing. In conducting its examination, the

4932 outside organization shall, to the extent possible, obtain and use actual health plan data from the
4933 all-payer claims database as administered by the institute of health care finance and policy; but
4934 such data shall be confidential and shall not be a public record for any purpose.

4935 (d) The commission shall report the results of its investigation and study and its
4936 recommendations, if any, together with drafts of legislation necessary to carry out such
4937 recommendations by March 31, 2017. The report shall be provided to the chairs of the house
4938 and senate ways and means committees and the joint committee on health care financing and
4939 shall be posted on the department's website.

4940 SECTION 192. (a) There shall be a commission on prevention and wellness which shall
4941 evaluate the effectiveness of the program authorized under section 2G of chapter 111 of the
4942 General Laws. The commission shall consist of 19 members: 1 of whom shall be the
4943 commissioner of public health or a designee, who shall serve as the chair; 1 of whom shall be the
4944 executive director of the institute of health care finance and policy established in chapter 12C or
4945 a designee; 1 of whom shall be the secretary of health and human services or a designee; 2 of
4946 whom shall be the house and senate chairs of the joint committee on public health; 2 of whom
4947 shall be the house and senate chairs of the joint committee on health care financing; and 12 of
4948 whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field
4949 of public health economics, 1 of whom shall be a person with expertise in public health research,
4950 1 of whom shall be a person with expertise in the field of health equity, 1 of whom shall be a
4951 person from a local board of health for a city or town with a population greater than 50,000, 1 of
4952 whom shall be a person of a board of health for a city or town with a population less than 50,000,
4953 2 of whom shall be representatives of health insurance carriers, 1 of whom shall be a person from
4954 a consumer health organization, 1 of whom shall be a person from a hospital association, 1 of

4955 whom shall be a person from a statewide public health organization, 1 of whom shall be a
4956 representative of the interest of businesses, and 1 of whom shall be a person from an association
4957 representing community health workers.

4958 (b) The commission shall review the program authorized under said section 2G of said
4959 chapter 111 and shall issue a report. The report shall include an analysis of all relevant data to
4960 determine the effectiveness and return on investment of the program including, but not limited
4961 to, an analysis of: (i) the extent to which the program impacted the prevalence of preventable
4962 health conditions; (ii) the extent to which the program reduced health care costs or the growth in
4963 health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the
4964 reduction; (iv) the extent to which workplace-based wellness or health management programs
4965 were expanded, and whether those programs improved employee health, productivity and
4966 recidivism; (v) if employee health and productivity was improved or employee recidivism was
4967 reduced, the estimated statewide financial benefit to employers; (vi) recommendations for
4968 whether the program should be discontinued, amended or expanded, as well as a timetable for
4969 implementation of the recommendations; and (vii) the extent to which additional funding is
4970 needed for the Prevention and Wellness Trust Fund, as established in said section 2G of said
4971 chapter 111, and a recommendation for a funding mechanism beyond 2017.

4972 (c) To conduct its evaluation, the commission shall contract with an outside organization
4973 with expertise in the analysis of health care financing. In conducting its evaluation, the outside
4974 organization shall, to the extent possible, obtain and use actual health plan data from the all-
4975 payer claims database as administered by the institute of health care finance and policy;
4976 provided, however, that such data shall be confidential and shall not be a public record under
4977 clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

4978 (d) The commission shall report the results of its investigation and study and its
4979 recommendation, if any, together with drafts of legislation necessary to carry out such
4980 recommendation to the house and senate committees on ways and means, the joint committee on
4981 public health and shall be posted on the department's website not later than March 31, 2017.

4982 SECTION 193. (a) Notwithstanding any general or special law to the contrary, this
4983 section shall facilitate the orderly transfer of employees, proceedings, rules and regulations,
4984 property and legal obligations of the following functions of state government from the transferor
4985 agency to the transferee agency, defined as follows:

4986 (1) the functions of the division of health care finance and policy, as the transferor
4987 agency, to the institute of health care finance and policy, as the transferee agency; provided
4988 however, that this section shall not apply to the functions of the division of health care finance
4989 and policy that relate to the administration of the health safety net fund;

4990 (2) the functions of the division of health care finance and policy related to the
4991 administration of the health safety net fund, as the transferor agency, to the office of Medicaid,
4992 as the transferee agency;

4993 (3) the functions of the health care quality and cost council, as the transferor
4994 agency, to the institute of health care finance and policy, as the transferee agency.

4995 (b) To the extent that employees of the transferor agency, including those who were
4996 appointed immediately before the effective date of this act and who hold permanent appointment
4997 in positions classified under chapter 31 of the General Laws or have tenure in their positions as
4998 provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold
4999 confidential positions, are transferred to the respective transferee agency, such transfers shall be

5000 effected without interruption of service within the meaning of said section 9A of said chapter 31,
5001 without impairment of seniority, retirement or other rights of the employee, and without
5002 reduction in compensation or salary grade, notwithstanding any change in title or duties resulting
5003 from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and
5004 benefits, and without change in union representation or certified collective bargaining unit as
5005 certified by the state division of labor relations or in local union representation or affiliation. Any
5006 collective bargaining agreement in effect immediately before the transfer date shall continue in
5007 effect and the terms and conditions of employment therein shall continue as if the employees had
5008 not been so transferred. The reorganization shall not impair the civil service status of any such
5009 reassigned employee who immediately before the effective date of this act either holds a
5010 permanent appointment in a position classified under chapter 31 of the General Laws or has
5011 tenure in a position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding
5012 any other general or special law to the contrary, all such employees shall continue to retain their
5013 right to collectively bargain pursuant to chapter 150E of the General Laws and shall be
5014 considered employees for the purposes of said chapter 150E. Nothing in this section shall be
5015 construed to confer upon any employee any right not held immediately before the date of said
5016 transfer, or to prohibit any reduction of salary grade, transfer, reassignment, suspension,
5017 discharge, layoff, or abolition of position not prohibited before such date.

5018 (c) All petitions, requests, investigations and other proceedings appropriately and duly
5019 brought before the transferor agency or duly begun by the transferor agency and pending before
5020 it before the effective date of this act, shall continue unabated and remain in force, but shall be
5021 assumed and completed by the transferee agency.

5022 (d) All orders, rules and regulations duly made and all approvals duly granted by the
5023 transferor agency, which are in force immediately before the effective date of this act, shall
5024 continue in force and shall thereafter be enforced, until superseded, revised, rescinded or
5025 canceled, in accordance with law, by the transferee agency.

5026 (e) All books, papers, records, documents, equipment, buildings, facilities, cash and other
5027 property, both personal and real, including all such property held in trust, which immediately
5028 before the effective date of this act are in the custody of the transferor agency shall be transferred
5029 to the transferee agency.

5030 (f) All duly existing contracts, leases and obligations of the transferor agency shall
5031 continue in effect but shall be assumed by the transferee agency. No existing right or remedy of
5032 any character shall be lost, impaired or affected by this act.

5033 SECTION 194. Notwithstanding any general or special law to the contrary, the
5034 commissioner of health care finance and policy as of the effective date of this act shall, with the
5035 approval of the governor, become the interim executive director of the institute of health care
5036 finance and policy on the effective date of this act. The interim executive director shall serve at
5037 the pleasure of the governor, and may be removed by the governor at any time. If there is a
5038 vacancy in the office of the interim executive director before January 1, 2014, the executive
5039 director of the institute of health care finance and policy shall be appointed by a majority vote of
5040 the governor, the auditor and the attorney general as required under section 2 of chapter 12C of
5041 the General Laws.

5042 Beginning on January 1, 2014, the executive director of the institute of health care
5043 finance and policy shall be appointed by a majority vote of the governor, the auditor and the
5044 attorney general as required under section 2 of chapter 12C of the General Laws.

5045 SECTION 195. Notwithstanding any general or special law or rule or regulation to the
5046 contrary, all orders, rules and regulations duly made and all approvals duly granted by the
5047 transferor agency, the division of health care finance and policy, in relation to sections 2A, 6B, 7,
5048 9 to 15, 17, 25 and 28 to 39 of chapter 118G of the General Laws, which are in force
5049 immediately before the effective date of this act, shall continue in force and shall thereafter be
5050 enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the
5051 transferee agency, the executive office of health and human services.

5052 SECTION 196. Notwithstanding any general or special law or rule or regulation to the
5053 contrary, all orders, rules and regulations duly made and all approvals duly granted by the
5054 transferor agency, the division of health care finance and policy, in relation to section 18 of
5055 chapter 15A, sections 6C and 18B of chapter 118G and section 188 of chapter 149 of the General
5056 Laws, which are in force immediately before the effective date of this act, shall continue in force
5057 and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance
5058 with law, by the transferee agency, the commonwealth health insurance connector.

5059 SECTION 197. Notwithstanding any general or special law or rule or regulation to the
5060 contrary, all orders, rules and regulations duly made and all approvals duly granted by the
5061 transferor agency, the division of health care finance and policy, in relation to sections 5, 6, 6A,
5062 6½, 8, 16 and 23 of chapter 118G of the General Laws, which are in force immediately before
5063 the effective date of this act, shall continue in force and shall thereafter be enforced, until

5064 superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency, the
5065 institute of health care finance and policy.

5066 SECTION 198. Notwithstanding any general or special law or rule or regulation to the
5067 contrary, all orders, rules and regulations duly made and all approvals duly granted by the
5068 transferor agency, the division of health care finance and policy, in relation to section 41 chapter
5069 118G of the General Laws, which are in force immediately before the effective date of this act,
5070 shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or
5071 canceled, in accordance with law, by the transferee agency, the department of public health.

5072 SECTION 199. The division of insurance shall develop prior authorization forms under
5073 section 24 of chapter 176O of the General Laws not later than July 1, 2013.

5074 SECTION 200. Section 87 shall take effect on January 1, 2015.

5075 SECTION 201. Section 70 of chapter 118E of the General Laws shall take effect on July
5076 1, 2012.

5077 SECTION 202. Section 70 of chapter 118E of the General Laws is hereby repealed.

5078 SECTION 203. Sections 144 and 147 shall take effect on July 1, 2013.

5079 SECTION 204. Sections 191 and 192 shall take effect on July 1, 2016.

5080 SECTION 205. Section 202 shall take effect on July 1, 2017.