

SENATE No. 2400

The Commonwealth of Massachusetts

The committee of conference, to whom was referred the matters of difference between the two branches with reference to the House amendment to the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2270) (amended by the House by striking out all after the enacting clause and inserting in place thereof the text of House document numbered 4155), reports, a Bill entitled “An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation” (Senate, No. 2400).

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SENATE No. 2400

Senate, July 31, 2012 – The committee of conference, to whom was referred the matters of difference between the two branches with reference to the House amendment to the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2270) (amended by the House by striking out all after the enacting clause and inserting in place thereof the text of House document numbered 4155), reports, a Bill entitled “An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation” (Senate, No. 2400).

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, 37, 39, 48 and 49, 54 and
3 55, and 86, the words “division of health care finance and policy” and inserting in place thereof,
4 in each instance, the following words:- center for health information and analysis.

5 SECTION 2. Said section 38C of said chapter 3, as so appearing, is hereby further
6 amended by striking out, in lines 35, 40, 44 and 45, 89 and 93, the word “division” and inserting
7 in place thereof, in each instance, the following word:- center.

8 SECTION 2A. Said section 38C of said chapter 3, as so appearing, is hereby further
9 amended by striking out, in line 47, the word “division’s” and inserting in place thereof the
10 following word:- center’s.

11 SECTION 3. Said section 38C of said chapter 3, as so appearing, is hereby amended by
12 striking out, in line 43, the words “, the health care quality and cost council,”.

13 SECTION 4. Section 105 of chapter 6 of the General Laws is hereby amended by striking
14 out, in lines 11 and 12, as so appearing, the words “commissioner of health care finance and
15 policy” and inserting in place thereof the following words:- executive director of the center for
16 health information and analysis.

17 SECTION 5. Section 16 of chapter 6A of the General Laws, as appearing in the 2010
18 Official Edition, is hereby amended by striking out, in line 52, the words “pursuant to section 2A
19 of chapter 118G” and inserting in place thereof the following words:— under section 13C of
20 chapter 118E.

21 SECTION 6. Section 16E of said chapter 6A is hereby repealed.

22 SECTION 7. Sections 16J to 16L, inclusive, of said chapter 6A are hereby repealed.

23 SECTION 8. Section 16M of said chapter 6A, as appearing in the 2010 Official Edition,
24 is hereby amended by striking out, in lines 3 and 4, the words “commissioner of health care
25 financing and policy” and inserting in place thereof the following words:- executive director of
26 the center for health information and analysis.

27 SECTION 9. Said section 16M of said chapter 6A, as so appearing, is hereby further
28 amended by striking out, in lines 23 and 39, the words “division of health care finance and
29 policy” and inserting in place thereof, in each instance, the following words:- center for health
30 information and analysis.

SECTION 10. Said section 16M of said chapter 6A, as so appearing, is hereby further amended by striking out, in line 24, the word “118G” and inserting in place thereof the following word:- 12C.

SECTION 11. Said section 16M of said chapter 6A, as so appearing, is hereby further amended by striking out, in lines 32 and 43, the word “division” and inserting in place thereof, in each instance, the following word:- center.

SECTION 12. Section 16N of said chapter 6A, as so appearing, is hereby amended by striking out, in lines 5 and 6, the words “commissioner of health care finance and policy” and inserting in place thereof the following words:- executive director of the center for health information and analysis.

SECTION 13. The first paragraph of subsection (a) of section 16O of said chapter 6A, as so appearing, is hereby amended by striking out the fifth sentence.

SECTION 14. Said chapter 6A is hereby further amended by adding the following section:-

Section 16T.(a) There shall be a health planning council within the executive office of health and human services, consisting of the secretary of health and human services or a designee who shall serve as chair, the commissioner of public health or a designee, the director of the office of Medicaid or a designee, the commissioner of mental health or a designee, the secretary of elder affairs or a designee, the executive director of the center for health information and analysis or a designee, the executive director of the health policy commission or a designee and 3 members appointed by the governor, of whom shall be a health economist; 1 of whom shall have

experience in health policy and planning and 1 of whom shall have experience in health care market planning and service line analysis.

The council shall assemble an advisory committee of not more than 13 members who shall reflect a broad distribution of diverse perspectives on the health care system, including health care providers and provider organizations, third-party payers, both public and private, consumer representatives and labor organizations representing health care workers. The advisory committee shall review drafts and provide recommendations to the council during the development of the plan.

The executive office of health and human services, with the council, shall conduct at least 5 public hearings, in geographically diverse areas, on the plan as proposed and shall give interested persons an opportunity to submit their views orally and in writing. In addition, the executive office may create and maintain a website to allow members of the public to submit comments electronically and review comments submitted by others. The state health plan shall identify needs of the commonwealth in health care services, providers, programs and facilities; the resources available to meet those needs; and the priorities for addressing those needs.

(b) The state health plan developed by the council shall include the location, distribution and nature of all health care resources in the commonwealth and shall establish and maintain on a current basis an inventory of all such resources together with all other reasonably pertinent information concerning such resources. For purposes of this section, a health care resource shall include any resource, whether personal or institutional in nature and whether owned or operated by any person, the commonwealth or political subdivision thereof, the principal purpose of which is to provide, or facilitate the provision of, services for the prevention, detection, diagnosis

or treatment of those physical and mental conditions experienced by humans which usually are the result of, or result in, disease, injury, deformity or pain.

The plan shall identify certain categories of health care resources, including acute care units; non-acute care units; specialty care units, including, but not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; skilled nursing facilities; assisted living facilities; long-term care facilities; home health, behavioral health and mental health services; treatment and prevention services for alcohol and other drug abuse; emergency care; ambulatory care services; primary care resources; pharmacy and pharmacological services; family planning services; obstetrics and gynecology services; allied health services including, but not limited to, optometric care, chiropractic services, dental care and midwifery services; federally qualified health centers and free clinics; numbers of technologies or equipment defined as innovative services or new technologies by the department under section 25C of chapter 111; and health screening and early intervention services.

The plan shall also make recommendations for the appropriate supply and distribution of resources, programs, capacities, technologies and services identified in the second paragraph of this subsection on a state-wide or regional basis based on an assessment of need for the next 5 years and options for implementing such recommendations. The recommendations shall reflect at least the following goals: to maintain and improve the quality of health care services; to support the state's efforts to meet the health care cost growth benchmark established under section 9 of chapter 6D; to support innovative health care delivery and alternative payment models as identified by the commission; to reduce unnecessary duplication; to support universal access to community-based preventative and patient-centered primary health care; to reduce health

disparities; to support efforts to integrate mental health, behavioral and substance use disorder services with overall medical care; to reflect the latest trends in utilization and support the best standards of care; and to rationally distribute health care resources across geographic regions of state based on the needs of the population on a statewide basis, as well as, the needs of particular geographic areas of the state.

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

(d) The department may require health care resources to provide information for the purposes of this section and may prescribe by regulation uniform reporting requirements. In prescribing such regulations the department shall strive to make any reports required under this section of mutual benefit to those providing, as well as, those using such information and shall avoid placing any burdens on such providers which are not reasonably necessary to accomplish this section. Agencies of the commonwealth which collect cost or other data concerning health care resources shall cooperate with the department in coordinating such data with information collected under this section.

The inventory compiled under subsection (b) and all related information shall be maintained in a form usable by the general public in a designated office of the department, shall constitute a public record and shall be coordinated with information collected by the department under other laws, federal census information and other vital statistics from reliable sources;

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

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

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

SECTION 15. The General Laws are hereby amended by inserting after chapter 6C the following chapter:-

CHAPTER 6D

HEALTH POLICY COMMISSION

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

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

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

143 “Accountable care organization” or “ACO”, a provider organization certified under
144 section 15.

145 “ACO participant”, a health care provider that either integrates or contracts with an ACO
146 to provide services to ACO patients.

147 “ACO patient”, an individual who chooses or is attributed to an ACO for medical and
148 behavioral health care, for whom such services are paid by the payer to the ACO.

149 “After-hours care”, services provided in the office during regularly scheduled evening,
150 weekend or holiday office hours, in addition to basic service.

151 “Allowed amount”, the contractually agreed upon amount paid by a payer to a health care
152 provider for health care services provided to an insured.

153 “Alternative payment contract”, any contract between a provider or provider organization
154 and a health care payer which utilizes alternative payment methodologies.

155 “Alternative payment methodologies or methods”, methods of payment that are not solely
156 based on fee-for-service reimbursements; provided that, “alternative payment methodologies”
157 may include, but shall not be limited to, shared savings arrangement, bundled payments and
158 global payments; provided further, that “alternative payment methodologies” may include fee-
159 for-service payments, which are settled or reconciled with a bundled or global payment.

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

“Center”, the center for health information and analysis established under chapter 12C.

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

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

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

“Commission”, health policy commission established by section 2.

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

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

“Disproportionate share hospital”, any acute hospital that exhibits a payer mix where a minimum of 63 per cent of the acute hospital’s gross patient service revenue is attributable to Title XVIII and Title XIX of the Federal Social Security Act, other government payors and free care. “Emergency services”, medically necessary health care services provided to an individual with an emergency medical condition.

“Employee”, a person who performs services primarily in the commonwealth for remuneration for a commonwealth employer. A person who is self-employed shall not be deemed to be an employee.

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

“Executive director”, the executive director of the health policy commission.

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

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

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

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

“Global payment”, a payment arrangement where spending targets are established for a comprehensive set of health care services for the care that a defined population of patients may receive in a specified period of time.

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

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

“Gross state product”, the total annual output of the Massachusetts economy as measured by the U.S. Department of Commerce, Bureau of Economic Analysis, Gross Domestic Product by State series.

“Growth rate of potential gross state product”, the long-run average growth rate of the commonwealth’s economy, excluding fluctuations due to the business cycle, as established under section 7H ½ of chapter 29.

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

“Health care cost growth benchmark,” the projected annual percentage change in total health care expenditures in the commonwealth, as established in section 9.

“Health care entity”, a provider, provider organization or carrier.

220 “Health care provider”, a provider of medical or health services or any other person or
221 organization that furnishes, bills or is paid for health care service delivery in the normal course
222 of business.

223 “Health care services”, supplies, care and services of medical, behavioral health,
224 substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic,
225 psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature
226 including, but not limited to, inpatient and outpatient acute hospital care and services; services
227 provided by a community health center home health and hospice care provider, or by a
228 sanatorium, as included in the definition of “hospital” in Title XVIII of the federal Social
229 Security Act, and treatment and care compatible with such services or by a health maintenance
230 organization.

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

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

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

240 “Health status adjusted total medical expenses”, the total cost of care for the patient
241 population associated with a provider group based on allowed claims for all categories of

242 medical expenses and all non-claims related payments to providers, adjusted by health status,
243 and expressed on a per member per month basis, as calculated under section 8 of chapter 12C.

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

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

249 “Medicaid program”, the medical assistance program administered by the office of
250 Medicaid under chapter 118E and under Title XIX of the Federal Social Security Act or any
251 successor statute.

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

255 “Medical service corporation”, a corporation established for the purpose of operating a
256 nonprofit medical service plan as provided in chapter 176B.

257 “Medicare program”, the medical insurance program established by Title XVIII of the
258 Federal Social Security Act.

259 “Net cost of private health insurance”, the difference between health premiums earned
260 and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as
261 included in medical loss ratio regulations promulgated by the division of insurance; (ii) net

additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise defined by regulations promulgated by the center under chapter 12C.

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

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

“Patient-centered medical home”, a model of health care delivery designed to provide a patient with a single point of coordination for all their health care, including primary, specialty, post-acute and chronic care, which is (i) patient-centered; (ii) comprehensive, integrated and continuous; and (iii) delivered by a team of health care professionals to manage a patient’s care, reduce fragmentation and improve patient outcomes.

“Patient decision aid”, an interactive, written or audio-visual tool that provides a balanced presentation of the condition and treatment or screening options, benefits and harms, with attention to the patient’s preferences and values.

“Payer”, any entity, other than an individual, that pays providers for the provision of health care services; provided, that “payer” shall include both governmental and private entities; provided further, that “payer” shall not include excludes ERISA plans.

“Performance improvement plan,” a plan submitted to the commission by a carrier, a provider or a provider organization under section 10.

“Performance incentive payment” or “pay-for-performance”, an amount paid to a provider by a payer for achieving certain quality measures as defined in this chapter.

“Performance penalty”, a reduction in the payments made by a payer to a provider for failing to achieve certain quality measures as defined in this chapter.

283 “Physician”, a medical or osteopathic doctor licensed to practice medicine in the
284 commonwealth.

285 “Primary care physician”, a physician who has a primary specialty designation of internal
286 medicine, general practice, family practice, pediatric practice or geriatric practice.

287 “Primary care provider”, a health care professional qualified to provide general medical
288 care for common health care problems, who supervises, coordinates, prescribes or otherwise
289 provides or proposes health care services, initiates referrals for specialist care and maintains
290 continuity of care within the scope of practice.

291 “Private health care payer”, (i) a carrier authorized to transact accident and health
292 insurance under chapter 175, (ii) a nonprofit hospital service corporation licensed under chapter
293 176A, (iii) a nonprofit medical service corporation licensed under chapter 176B, (iv) a dental
294 service corporation organized under chapter 176E, (v) an optometric service corporation
295 organized under chapter 176F, (vi) a self-insured plan, to the extent allowable under federal law
296 governing health care provided by employers to employees, or (vii) a health maintenance
297 organization licensed under chapter 176G.

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

301 “Provider organization”, any corporation, partnership, business trust, association or
302 organized group of persons, which is in the business of health care delivery or management,
303 whether incorporated or not that represents 1 or more health care providers in contracting with
304 carriers for the payments of health care services; provided, that “provider organization” shall

include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for health care services.

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

“Quality measures”, the standard quality measure set as defined by the center under section 14 of chapter 12C.

“Registered provider organization”, a provider organization that has been registered under this chapter.

“Relative prices”, the contractually negotiated amounts paid to providers by each private and public carrier for health care services, including non-claims related payments and expressed in the aggregate relative to the payer’s network-wide average amount paid to providers, as calculated under section 10 of chapter 12C.

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

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

328 “Risk-bearing provider organization”, a provider organization that manages the treatment
329 of a group of patients and bears the downside risk according to the terms of an alternate payment
330 contract.

331 “Secretary”, the secretary of health and human services.

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

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

337 “Self-insured group”, a self-insured or self-funded employer group health plan.

338 “Shared decision-making”, a process in which the health care provider and patient or
339 patient’s representative discuss the patient’s condition or disease, the treatment options available
340 for that condition or disease, the benefits and harms of each treatment option, information on the
341 limits of scientific knowledge on patient outcomes from the treatment options, and the patient’s
342 values and preferences for treatment, and if available for said condition or disease, with the use
343 of a patient decision aid.

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

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

“Third party administrator”, an entity that administers payments for health care services on behalf of a client in exchange for an administrative fee.

“Title XIX”, Title XIX of the Federal Social Security Act, 42 U.S.C. 1396 et seq., or any successor statute enacted into federal law for the same purposes as Title XIX.

“Total health care expenditures”, the annual per capita sum of all health care expenditures in the commonwealth from public and private sources, including: (i) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses reported by the center under subsection (d) of section 8 of chapter 12C; (ii) all patient cost-sharing amounts, such as, deductibles and copayments; and (iv) the net cost of private health insurance, or as otherwise defined in regulations promulgated by the center.

Section 2. (a) There shall be established within the executive office for administration and finance, but not under its control, a state agency known as the health policy commission. The commission shall be an independent public entity not subject to the supervision and control

of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth.

(b) There shall be a board, with duties and powers established by this chapter, which shall govern the commission. The board shall consist of 11 members: 1 of whom shall be the secretary for administration and finance, ex officio; 1 of whom shall be the secretary of health and human services, ex-officio; and 3 of whom shall be appointed by the governor, 1 of whom shall serve as chairperson; 3 of whom shall be appointed by the attorney general; and three members shall be appointed by the auditor. All appointments after the initial term of appointment shall serve a term of 5 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment; however, no appointed member shall hold full or part-time employment in the executive branch of state government. The board shall annually elect 1 of its members to serve as vice-chairperson. Each member of the board shall be a resident of the commonwealth. Each member of the board serving ex officio may appoint a designee under section 6A of chapter 30.

The person appointed by the governor to serve as chairperson shall have demonstrated expertise in health care delivery, health care management at a senior level or health care finance and administration, including payment methodologies. The initial appointment of the chairperson shall be for a term of 3 years; provided, however, that subsequent appointments shall be for a term of 5 years. The second person appointed by the governor, shall have demonstrated expertise in health plan administration and finance and shall be initially appointed for a term of 4 years. The third person appointed by the governor, shall be a primary care physician and shall be initially appointed for a term of 5 years. Of those persons appointed by the attorney general, 1 shall have demonstrated expertise in health care consumer advocacy and shall be initially

391 appointed for a term of 2 years; 1 shall be a health economist and shall be initially appointed for
392 a term of 3 years; and 1 shall have expertise in behavioral health, substance use disorder, mental
393 health services and mental health reimbursement systems and shall be initially appointed for a
394 term of 1 year. Of those persons appointed by the auditor, 1 shall have demonstrated expertise in
395 representing the health care workforce as a leader in a labor organization and shall be initially
396 appointed for a term of 4 years; 1 shall have demonstrated expertise as a purchaser of health
397 insurance representing business management or health benefits administration and shall be
398 initially appointed for a term of 3 years; and 1 shall have demonstrated expertise in the
399 development and utilization of innovative medical technologies and treatments for patient care
400 and shall be initially appointed for a term of 2 years.

401 (c) Six members of the board shall constitute a quorum, and the affirmative vote of 6
402 members of the board shall be necessary and sufficient for any action taken by the board. No
403 vacancy in the membership of the board shall impair the right of a quorum to exercise all the
404 rights and duties of the commission. Members shall serve without pay, but shall be reimbursed
405 for actual expenses necessarily incurred in the performance of their duties. A member of the
406 board shall not be employed by, a consultant to, a member of the board of directors of, affiliated
407 with, have a financial stake in or otherwise be a representative of a health care entity while
408 serving on the board.

409 (d) Any action of the commission may take effect immediately and need not be published
410 or posted unless otherwise provided by law. Meetings of the commission shall be subject to
411 sections 18 to 25, inclusive, of chapter 30A; provided however that said sections shall not apply
412 to any meeting of members of the commission serving ex officio in the exercise of their duties as
413 officers of the commonwealth if no matters relating to the official business of the commission

are discussed and decided at the meeting. The commission shall be subject to all other provisions of said chapter 30A, and records pertaining to the administration of the commission shall be subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the commission shall be considered to be public funds for purposes of chapter 12A. Except as otherwise provided in this section, the operations of the commission shall be subject to chapter 268A and chapter 268B.

The commission shall not be required to obtain the approval of any other officer or employee of any executive agency in connection with the collection or analysis of any information; nor shall the commission be required, prior to publication, to obtain the approval of any other officer or employee of any executive agency with respect to the substance of any reports which the commission has prepared under this chapter.

(e) The board shall appoint an executive director by a majority vote. The executive director shall supervise the administrative affairs and general management and operations of the commission and also serve as secretary of the commission, ex officio. The executive director shall receive a salary commensurate with the duties of the office. The executive director may appoint other officers and employees of the commission necessary to the functioning of the commission.

The executive director shall not be required to obtain the approval of any other executive agency in connection with appointment of employees. Sections 9A, 45, 46 and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director of the commission. Sections 45, 46 and 46C of chapter 30 shall not apply to any employee of the commission. The

435 executive director may establish personnel regulations for the officers and employees of the
436 commission.

437 The executive director shall file an annual personnel report not later than the first
438 Wednesday in February with the senate and house committees on ways and means containing the
439 job classifications, duties and salary of each officer and employee within the center together with
440 personnel regulations applicable to said officers and employees. The executive director shall file
441 amendments to such report with the senate and house committees on ways and means whenever
442 any changes become effective.

443 The executive director shall, with the approval of the board:

444 (i) plan, direct, coordinate and execute administrative functions in conformity with the
445 policies and directives of the board;

446 (ii) employ professional and clerical staff as necessary;

447 (iii) report to the board on all operations under their control and supervision;

448 (iv) prepare an annual budget and manage the administrative expenses of the
449 commission; and

450 (v) undertake any other activities necessary to implement the powers and duties under this
451 chapter.

452 The board may approve the use of funds from the Healthcare Payment Reform Fund to
453 support the annual budget of the commission, in addition to funds from any other source and any
454 funds appropriated therefor by the general court. The commission shall not be required to obtain

the approval of any other executive agency in connection with the development and administration of its annual budget.

(f) Chapter 268A shall apply to all board members, except that the commission may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any board member is in anyway interested or involved; provided, however, that such interest or involvement shall be disclosed in advance to the board and recorded in the minutes of the proceedings of the board; and provided further, that no member shall be deemed to have violated section 4 of said chapter 268A because of such member's receipt of such member's usual and regular compensation from such member's employer during the time in which the member participates in the activities of the board.

(g) The executive director shall appoint and may remove such agents and subordinate officers as the executive director may consider necessary and may establish such subdivisions within the commission as the executive director considers appropriate to fulfill the purposes under this chapter,.

The commission shall adopt and amend rules and regulations, under chapter 30A, for the administration of its duties and powers and to effectuate this chapter.

Section 3. For the purposes of this chapter, the board shall be authorized and empowered as follows:

(a) to develop a plan of operation for the commission. The plan of operation shall include, but not be limited to:

(1) implementation of procedures for operations of the commission; and

476 (2) implementation of procedures for communications with the executive director;

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

478 (c) to make contracts and execute all instruments necessary or convenient for the carrying
479 on of its business;

480 (d) to acquire, own, hold, dispose of and encumber personal property and to lease real
481 property in the exercise of its powers and the performance of its duties;

482 (e) to seek and receive any grant funding from the federal government, departments or
483 agencies of the commonwealth, and private foundations;

484 (f) to enter into and execute instruments in connection with agreements or transactions
485 with any federal, state or municipal agency or other public institution or with any private
486 individual, partnership, firm, corporation, association or other entity, including contracts with
487 professional service firms as may be necessary in its judgment, and to fix their compensation;

488 (g) to maintain a prudent level of reserve funds to protect the solvency of any trust funds
489 under the operation and control of the commission;

490 (h) to enter into interdepartmental agreements with any other state agencies the board
491 considers necessary to implement this chapter.

492 (i) to adopt an official seal and alter the same;

493 (j) to sue and be sued in its own name, plead and be impleaded;

494 (k) to establish lines of credit, and establish 1 or more cash and investment accounts to
495 receive payments for services rendered, appropriations from the commonwealth and for all other

business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974; and

(l) to approve the use of its trademarks, brand names, seals, logos and similar instruments by participating carriers, employers or organizations.

Section 4. There shall be an advisory council to the commission. The council shall advise on the overall operation and policy of the commission. The council shall be chosen by the executive director and shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, educational institutions, consumer representatives, medical device manufacturers, representatives of the biotechnology industry, pharmaceutical manufacturers, providers, provider organizations, labor organizations and public and private payers.

Section 5. The commission shall monitor the reform of the health care delivery and payment system in the commonwealth under this chapter. The commission shall: (i) set health care cost growth goals for the commonwealth; (ii) enhance the transparency of provider organizations; (iii) monitor the development of ACOs and patient-centered medical homes; (iv) monitor the adoption of alternative payment methodologies; (v) foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care; (vi) monitor and review the impact of changes within the health care marketplace and (vii) protect patient access to necessary health care services.

Section 6. Each acute hospital, ambulatory surgical center and surcharge payor shall pay to the commonwealth an amount for the estimated expenses of the commission.

The assessed amount for hospitals and ambulatory surgical centers shall be not less than 33 per cent of the amount appropriated by the general court for the expenses of the commission minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission; and (iii) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Each acute hospital and ambulatory surgical center shall pay such assessed amount multiplied by the ratio of the hospital's or ambulatory surgical center's gross patient service revenues to the total of all such hospital's and ambulatory surgical center's gross patient services revenues. Each acute hospital and ambulatory surgical center shall make a preliminary payment to the commission on October 1 of each year in an amount equal to $\frac{1}{2}$ of the previous year's total assessment. Thereafter, each hospital and ambulatory surgical center shall pay, within 30 days notice from the commission, the balance of the total assessment for the current year based upon its most current projected gross patient service revenue. The commission shall subsequently adjust the assessment for any variation in actual and estimated expenses of the commission and for changes in hospital or ambulatory surgical center gross patient service revenue. Such estimated and actual expenses shall include an amount equal to the cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D of chapter 29. In the event of late payment by any such hospital or ambulatory surgical center, the treasurer shall advance the amount of due and unpaid funds to the commission prior to the receipt of such monies in anticipation of such revenues up to the amount authorized in the then current budget attributable to such assessments and the commission shall reimburse the treasurer for such advances upon receipt of such revenues. This section shall not apply to any state institution or to any acute hospital which is operated by a city or town.

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

Section 7. (a) The commission, in consultation with the advisory council, shall administer the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of 2011. The fund shall be used for the following purposes: (1) to support the activities of the commission; and (2) to foster innovation in health care payment and service delivery.

(b) The commission shall establish a competitive process for health care entities to develop, implement or evaluate promising models in health care payment and health care service delivery. Assistance from the commission may take the form of incentives, grants, technical assistance, evaluation assistance or partnerships, as determined by the commission.

(c) Prior to making a request for proposals under subsection (b), the commission shall solicit ideas for health care payment and service reforms directly from providers, provider organizations, carriers, research institutions, health professionals, public institutions of higher education, community-based organizations and private-public partnerships, or any combination thereof. The commission shall review health care payment and service delivery models so submitted and shall seek input from other relevant stakeholders in evaluating their potential.

(d) The commission shall consider proposals that achieve 1 or more of the following goals: (i) to support safety-net provider and disproportionate share hospital participation in new payment and health care payment and service delivery models; (ii) to support the successful implementation of performance improvement plans by health care entities under subsection (c) of section 10; (iii) to support cooperative efforts between representatives of employees and management that are focused on controlling costs and improving the quality of care through workforce engagement; (iv) to support the evaluation of mobile health and connected health technologies to improve health outcomes among under-served patients with chronic diseases; (v) to develop the capacity to safely and effectively treat chronic, common and complex diseases in rural and underserved areas and to monitor outcomes of those treatments; and (vi) any other goals as determined by the commission.

(e) All approved activities funded through the Healthcare Payment Reform Fund shall support the commonwealth's efforts to meet the health care cost growth benchmark established under section 9 , and shall include measurable outcomes in both cost reduction and quality improvement.

(f) To the maximum extent feasible, the commission shall seek to coordinate expenditures from the Healthcare Payment Reform Fund with other public expenditures from the Prevention and Wellness Trust Fund, the E-Health Institute Fund, the Massachusetts Health Information Exchange Fund, the Distressed Hospital Trust Fund, the Health Care Workforce Transformation Trust Fund, the executive office of health and human services, any funding available through the Medicare program and the CMS Innovation Center, established under the federal Patient Protection and Affordable Care Act and any funding expended under the Delivery

System Transformation Initiative Master Plan and hospital-specific plans approved in the
MassHealth section 1115 demonstration waiver.

(g) Activities funded through the Healthcare Payment Reform Fund that demonstrate measurable success in improving care or reducing costs shall be shared with other providers, provider organizations and payers as model programs which may be voluntarily adopted by such other health care entities. The commission may also incorporate any successful models and practices into its standards for ACO certification under section 15 and for alternative payment methodologies established for state-funded programs.

(h) The commission shall, annually on or before January 31, report on expenditures from the Healthcare Payment Reform Fund. The report shall include, but not be limited to: (i) the revenue credited to the fund; (ii) the amount of fund expenditures attributable to the administrative costs of the commission; (iii) an itemized list of the funds expended through the competitive process and a description of the grantee activities; and (iv) the results of the evaluation of the effectiveness of the activities funded through grants. The report shall be provided to the chairs of the house and senate committees on ways and means and the joint committee on health care financing and shall be posted on the commission's website.

Section 8. (a) Not later than October 1 of every year, the commission shall hold public hearings based on the report submitted by the center for health information and analysis under section 16 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices and

cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system.

(b) The attorney general may intervene in such hearings.

(c) Public notice of any hearing shall be provided at least 60 days in advance.

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

(e) Witnesses shall provide testimony under oath and subject to examination and cross examination by the commission, the executive director of the center and the attorney general at

the public hearing in a manner and form to be determined by the commission, including, but not limited to: (i) in the case of providers and provider organizations, testimony concerning payment systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization trends, relative price, quality improvement and care-coordination strategies, investments in health information technology, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system, efforts to reduce the inappropriate or duplicative use of technology and the impact of price transparency on prices; and (ii) in the case of private and public payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, efforts by the payer to reduce the use of fee-for-service payment mechanisms, the payer's efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to promote the standardization of administrative practices, the impact of price transparency on prices and any other matters as determined by the commission. The commission shall solicit testimony from any payer which has been identified by the center's annual report under subsection (a) of section 16 of chapter 12C as (1) paying providers more than 10 per cent above or more than 10 per cent below the average relative price or (2) entering into alternative payment contracts that vary by more than 10 per cent. Any payer identified by the center's report shall explain the extent of price variation between the payer's participating providers and describe any efforts to reduce such price variation.

(f) In the event that the center's annual report under subsection (a) of section 16 of chapter 12C finds that the percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, the commission may identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross examination by the commission, the executive director of the center and attorney general at the public hearing in a manner and form to be determined by the commission, including, but not limited to: (i) testimony concerning unanticipated events that may have impacted the total health care cost expenditures, including, but not limited to, a public health crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity or utilization of services; (iii) testimony concerning trends in input cost structures, including, but not limited to, the introduction of new pharmaceuticals, medical devices and other health technologies; (iv) testimony concerning the cost of providing certain specialty services, including, but not limited to, the provision of health care to children, cancer-related health care and medical education; (v) testimony related to unanticipated administrative costs for carriers, including, but not limited to, costs related to information technology, administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related to costs due the implementation of state or federal legislation or government regulation; and (vii) any other factors that may have led to excessive health care cost growth.

(g) The commission shall compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The report shall be based on the commission's analysis of information provided at the hearings by providers, provider organizations and insurers, registration data

collected under section 11, data collected by the center for health information and analysis under sections 8, 9 and 10 of chapter 12C and any other information the commission considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the commission. The report shall be submitted to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include any legislative language necessary to implement the recommendations.

Section 9. (a) Not later than April 15 of every year, the board shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth for the next calendar year. The commission shall establish procedures to prominently publish the annual health care cost growth benchmark on the commission's website.

(b) The commission shall establish the annual health care cost growth benchmark as follows:

(1) For calendar years 2013 through 2017, the health care cost growth benchmark shall be equal to the growth rate of potential gross state product established under section 7H½ of chapter 29; provided, however, that the growth rate of potential gross state product for calendar year 2013 shall be 3.6 per cent.

(2) For calendar years 2018 through 2022, the health care cost growth benchmark shall be equal to the growth rate of potential gross state product established under said section 7H½ of said chapter 29, minus 0.5 per cent.

(3) For calendar years 2023 and beyond, the health care cost growth benchmark shall be equal to the growth rate of potential gross state product established under said section 7H½ of said chapter 29.

(c) For calendar years 2018 through 2022, if the commission determines that an adjustment in the health care cost growth benchmark is reasonably warranted, having first considered any testimony at the public hearing as required under subsection (f), the board of the commission may modify the health care cost growth benchmark such that the health care cost growth benchmark shall be set at an amount between minus 0.5 per cent of the growth of the potential gross state product and an amount equal to the growth of the potential gross state product.

(d) For calendar years 2018 through 2022, on or after January 15 but not later than January 31 of the second year of a biennial session of the general court, the board shall submit notice of its intention to modify the health care cost growth benchmark under subsection (c) to the joint committee on health care financing. Within 30 days of such filing, the joint committee shall hold a public hearing on the board's proposed modification to the health care cost growth benchmark. The joint committee shall report its findings to the general court together with any necessary legislation, including its recommendation, within 30 days of the public hearing and provide a copy of its findings and legislation to the board. If the general court does not enact legislation with respect to the board's recommended modification to the health care cost growth benchmark within 45 days of the public hearing, the board's modification to the health care cost growth benchmark shall take effect.

(e) For calendar years 2023 through 2032, if the commission determines that an adjustment in the health care cost growth benchmark is reasonably warranted, having first considered any testimony at a public hearing as required under subsection (f), the board of the commission may recommend a modification of the health care cost growth benchmark, in any amount as determined by the commission. On or after January 15 but not later than January 31 of the second year of a biennial session of the general court, the board shall submit notice of its recommendation for any modification to the joint committee on health care financing. Within 30 days of such filing, the joint committee may hold a public hearing on the board's proposed modification to the health care cost growth benchmark. The joint committee may report its findings, to the general court together with legislation, including its recommendation on whether to affirm or reject the board's recommendation, within 30 days of the public hearing and provide a copy of its findings and proposed legislation to the board.

(f) Prior to making any recommended modification to the health care cost growth benchmark under subsections (c), (d) and (e), the board shall hold a public hearing on any such recommended modification. The public hearing shall be based on the report submitted by the center under section 16 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year, any other data provided by the center and such other pertinent information or data as may be available to the board. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system, and whether, based on the testimony, information and data, a modification in the health care cost growth benchmark is appropriate. The commission shall provide public notice of such hearing at least 45 days prior to the date of

the hearing, including notice to the joint committee on health care financing. The joint committee on health care financing may participate in the hearing. The commission shall identify as witnesses for the public hearing a representative sample of providers, provider organizations, payers and such other interested parties as the commission may determine. Any other interested parties may testify at the hearing.

(g) Any recommendation of the commission to modify the health care cost growth benchmark under subsections (d) or (e) shall be approved by a two thirds vote of the board.

Section 10. (a) For the purposes of this section, “health care entity” shall mean a clinic, hospital, ambulatory surgical center, physician organization, accountable care organization or payer; provided, however, that physician contracting units with a patient panel of 15,000 or fewer, or which represents providers who collectively receive less than \$25,000, 000 in annual net patient service revenue from carriers shall be exempt.

(b) The commission shall provide notice to all health care entities that have been identified by the center under section 18 of chapter 12C as exceeding the health care cost growth benchmark for any given year. Such notice shall state that the center may analyze the cost growth of individual health care entities and, beginning in calendar year 2016, the commission may require certain actions, as established in this section, from health care entities so identified.

(c) For calendar year 2015, if the commission finds, based on the center’s annual report, the commission’s annual cost trend hearings or any other pertinent information, that the average percentage change in cumulative total health care expenditures from 2013 to 2014 exceeded the average health care cost growth benchmark from 2013 to 2014, and in order to support the state’s efforts to meet future health care cost growth benchmarks, as established in section 9, the

commission shall establish procedures to assist health care entities to improve efficiency and reduce cost growth by requiring certain health care entities to file and implement a performance improvement plan.

Beginning in calendar year 2016, if the commission finds, based on the center's annual report, the commission's annual cost trend hearings or any other pertinent information, that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in said section 9, the commission shall establish procedures to assist health care entities to improve efficiency and reduce cost growth by requiring certain health care entities to file and implement a performance improvement plan.

(d) In addition to the notice provided under subsection (b), the commission may require any health care entity that is identified by the center under section 16 of chapter 12C as exceeding the health care cost growth benchmark established under section 9 to file a performance improvement plan with the commission. The commission shall provide written notice to such health care entity that they are required to file a performance improvement plan. Within 45 days of receipt of such written notice, the health care entity shall either:

(1) file a performance improvement plan with the commission; or

(2) file an application with the commission to waive or extend the requirement to file a performance improvement plan.

(e) The health care entity may file any documentation or supporting evidence with the commission to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The commission shall require the health care entity to

778 submit any other relevant information it deems necessary in considering the waiver or extension
779 application; provided, however, that such information shall be made public at the discretion of
780 the commission.

781 (f) The commission may waive or delay the requirement for a health care entity to file a
782 performance improvement plan in response to a waiver or extension request filed under
783 subsection (b) in light of all information received from the health care entity, based on a
784 consideration of the following factors:

785 (1) the costs, price and utilization trends of the health care entity over time, and
786 any demonstrated improvement to reduce health status total medical expenses;

787 (2) any ongoing strategies or investments that the health care entity is
788 implementing to improve future long-term efficiency and reduce cost growth;

789 (3) whether the factors that led to increased costs for the health care entity can
790 reasonably be considered to be unanticipated and outside of the control of the entity. Such factors
791 may include, but shall not be limited to, age and other health status adjusted factors and other
792 cost inputs such as pharmaceutical expenses and medical device expenses;

793 (4) the overall financial condition of the health care entity;

794 (5) a significant difference between the growth rate of potential gross state
795 product and the growth rate of actual gross state product, as determined under section 7H ½ of
796 chapter 29; and

797 (6) any other factors the commission considers relevant.

(h) If the commission declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the commission shall provide written notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan.

(i) A health care entity shall file a performance improvement plan: (1) within 45 days of receipt of a notice under subsection (c); (2) if the health care entity has requested a waiver or extension, within 45 days of receipt of a notice that such waiver or extension has been denied; or (3) if the health care entity is granted an extension, on the date given on such extension. The performance improvement plan shall be generated by the health care entity and shall identify the causes of the entity's cost growth and shall include, but not be limited to, specific strategies, adjustments and action steps the entity proposes to implement to improve cost performance. The proposed performance improvement plan shall include specific identifiable and measurable expected outcomes and a timetable for implementation. The timetable for a performance improvement plan shall not exceed 18 months.

(j) The commission shall approve any performance improvement plan that it determines is reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable expectation for successful implementation.

(k) If the board determines that the performance improvement plan is unacceptable or incomplete, the commission may provide consultation on the criteria that have not been met and may allow an additional time period, up to 30 calendar days, for resubmission; provided, however, that all aspects of the performance improvement plan shall be proposed by the health care entity and the commission shall not require specific elements for approval.

820 (l) Upon approval of the proposed performance improvement plan, the commission shall
821 notify the health care entity to begin immediate implementation of the performance improvement
822 plan. Public notice shall be provided by the commission on its website, identifying that the
823 health care entity is implementing a performance improvement plan. All health care entities
824 implementing an approved performance improvement plan shall be subject to additional
825 reporting requirements and compliance monitoring, as determined by the commission. The
826 commission shall provide assistance to the health care entity in the successful implementation of
827 the performance improvement plan.

828 (m) All health care entities shall, in good faith, work to implement the performance
829 improvement plan. At any point during the implementation of the performance improvement
830 plan the health care entity may file amendments to the performance improvement plan, subject to
831 approval of the commission.

832 (n) At the conclusion of the timetable established in the performance improvement plan,
833 the health care entity shall report to the commission regarding the outcome of the performance
834 improvement plan. If the performance improvement plan was found to be unsuccessful, the
835 commission shall either: (i) extend the implementation timetable of the existing performance
836 improvement plan; (ii) approve amendments to the performance improvement plan as proposed
837 by the health care entity; (iii) require the health care entity to submit a new performance
838 improvement plan under subsection (c) or (iv) waive or delay the requirement to file any
839 additional performance improvement plans.

840 (o) Upon the successful completion of the performance improvement plan, the identity of
841 the health care entity shall be removed from the commission's website.

(p) The commission may submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this act, assist health care entities with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section.

(q) If the commission determines that a health care entity has: (i) willfully neglected to file a performance improvement plan with the commission within 45 days as required under subsection (d); (ii) failed to file an acceptable performance improvement plan in good faith with the commission; (iii) failed to implement the performance improvement plan in good faith; or (iv) knowingly failed to provide information required by this section to the commission or that knowingly falsifies the same, the commission may assess a civil penalty to the health care entity of not more than \$500,000. The commission shall seek to promote compliance with this section and shall only impose a civil penalty as a last resort.

(r) The commission shall promulgate regulations necessary to implement this section; provided, however, that notice of any proposed regulations shall be filed with the joint committee on state administration and regulatory oversight and the joint committee on health care financing at least 180 days before adoption.

or third-party administrators shall be excluded from this definition.

Section 11. (a) The commission shall develop and administer a registration program for provider organizations. A provider organization shall be registered for a term of 2 years and renewable under like terms. The commission shall coordinate with state agencies including, but not limited to, the center, the division of insurance, the executive office of health and human

864 services, the office of Medicaid and the department of public health to minimize duplicative
865 reporting requirements. The commission may enter interagency service agreements to perform
866 these functions including but not limited to the sharing of data collected. The commission, in
867 consultation with the center, shall promulgate such regulations as may be necessary to ensure the
868 uniform reporting of data collected under this section.

869 (b) The commission shall require that all provider organizations report the following
870 information for registration and renewal: (i) organizational charts showing the ownership,
871 governance and operational structure of the provider organization, including any clinical
872 affiliations, parent entities, corporate affiliates, and community advisory boards; (ii) the number
873 of affiliated health care professional full-time equivalents and the number of professionals
874 affiliated with or employed by the organization; (iii) the name and address of licensed facilities;
875 and (iv) such other information as the commission considers appropriate.

876 (c) Upon receiving an application for registration, the commission may, within 30 days,
877 require an applicant to provide additional information to complete or supplement the filing. The
878 commission shall determine whether an application is complete within 45 days of receipt of the
879 application and any supplementary information. The commission shall provide the applicant with
880 a written notice that provider organization's registration is complete and provide a copy of the
881 completed registration materials to the division of insurance. The commission may assess a
882 reasonable registration or administrative fee on the registration of provider organizations to
883 support the commission's operations and administration.

884 (d) The commission shall support the division of insurance in its review of risk-bearing
885 provider organizations under chapter 176U and the center in its efforts to collect and analyze

886 data. The commission shall promulgate regulations setting forth a process for provider
887 organizations to submit proposed changes to its structure.

888 (e) A risk bearing provider organization shall provide the commission with a division of
889 insurance risk certificate under chapter 176U. The commission may suspend, revoke or refuse to
890 renew a risk-bearing provider organization's registration for failure to proffer a risk certificate.

891 Section 12. (a) No provider or provider organization may negotiate network contracts
892 with any carrier or third-party administrator except for a provider or provider organizations
893 which are registered under this chapter and regulations promulgated under this chapter; provided,
894 however, that nothing in this chapter shall require a provider or provider organization with a
895 patient panel of 15,000 or fewer or which represents providers who collectively receive, less than
896 \$25,000,000 in annual net patient service revenue from carriers or third-party administrators to
897 be registered if such provider or provider is not a risk-bearing provider organization.

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

901 Section 13. (a) Every provider or provider organization shall, before making any
902 material change to its operations or governance structure, submit notice to the commission, the
903 center and the attorney general of such change, not fewer than 60 days before the date of the
904 proposed change. Material changes shall include, but not be limited to: a corporate merger,
905 acquisition or affiliation of a provider or provider organization and a carrier; mergers or
906 acquisitions of hospitals or hospital systems; acquisition of insolvent provider organizations; and

mergers or acquisitions of provider organizations which will result in a provider organization having a near-majority of market share in a given service or region.

Within 30 days of receipt of a notice filed under the commission's regulations, the commission shall conduct a preliminary review to determine whether the material change is likely to result in a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, established in section 9, or on the competitive market. If the commission finds that the material change is likely to have a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, or on the competitive market, the commission may conduct a cost and market impact review under this section.

(b) In addition to the grounds for a cost and market impact review set forth in subsection (a), if the commission finds, based on the center's annual report, that the percentage change in total health care expenditures exceeded the health care cost growth benchmark in the previous calendar year, the commission may conduct a cost and market impact review of any provider organization identified by the center under section 16 of chapter 12C.

(c) The commission shall initiate a cost and market impact review by sending the provider or provider organization notice of a cost and market impact review which shall explain the basis for the review and the particular factors that the commission seeks to examine through the review. The provider organization shall submit to the commission, within 21 days of the commission's notice, a written response to the notice, including, but not limited to, any information or documents sought by the commission which are described in the commission's notice.

(d) A cost and market impact review may examine factors relating to the provider or provider organization's business and its relative market position, including, but not limited to:

(i) the provider or provider organization's size and market share within its primary service areas by major service category, and within its dispersed service areas; (ii) the provider or provider organization's prices for services, including its relative price compared to other providers for the same services in the same market; (iii) the provider or provider organization's health status adjusted total medical expense, including its health status adjusted total medical expense compared to similar providers; (iv) the quality of the services it provides, including patient experience; (v) provider cost and cost trends in comparison to total health care expenditures statewide; (vi) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider or provider organization within its primary service areas and dispersed service areas; (vii) the provider or provider organization's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas including, if applicable, the impact on existing service providers of a provider or provider organization's expansion, affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not previously operate; (viii) the methods used by the provider or provider organization to attract patient volume and to recruit or acquire health care professionals or facilities; (ix) the role of the provider or provider organization in serving at-risk, underserved and government payer patient populations, including those with behavioral, substance use disorder and mental health conditions, within its primary service areas and dispersed service areas; (x) the role of the provider or provider organization in providing low margin or negative margin services within its primary service areas and dispersed service areas; (xi) consumer concerns, including but not limited to, complaints or other

951 allegations that the provider or provider organization has engaged in any unfair method of
952 competition or any unfair or deceptive act or practice; and (xii) any other factors that the
953 commission determines to be in the public interest.

954 (e) The commission shall make factual findings and issue a preliminary report on the
955 cost and market impact review. In the report, the commission shall identify any provider or
956 provider organization that meets all of the following criteria: (i) the provider or provider
957 organization has a dominant market share for the services it provides; (ii) the provider or
958 provider organization charges prices for services that are materially higher than the median
959 prices charged by all other providers for the same services in the same market; and (iii) the
960 provider or provider organization has a health status adjusted total medical expense that is
961 materially higher than the median total medical expense for all other providers for the same
962 service in the same market.

963 (f) Within 30 days after issuance of a preliminary report, the provider or provider
964 organization may respond in writing to the findings in the report. The commission shall then
965 issue its final report. The commission shall refer to the attorney general its report on any
966 provider organization that meets all 3 criteria under subsection (e).

967 (g) Nothing in this section shall prohibit a proposed material change under subsection (a);
968 provided, however, that any proposed material change shall not be completed until at least 30
969 days after the commission has issued its final report.

970 (h) When the commission, under subsection (f), refers a report on a provider or provider
971 organization to the attorney general, the attorney general may: (i) conduct an investigation to
972 determine whether the provider or provider organization engaged in unfair methods of

973 competition or anti-competitive behavior in violation of chapter 93A or any other law; (ii) report
974 to the commission in writing the findings of the investigation and a conclusion as to whether the
975 provider or provider organization engaged in unfair methods of competition or anti-competitive
976 behavior in violation of chapter 93A or any other law; and (iii) if appropriate, take action under
977 chapter 93A or any other law to protect consumers in the health care market. The commission's
978 final report may be evidence in any such action.

979 (i) Nothing in this section shall limit the authority of the attorney general to protect
980 consumers in the health care market under any other law.

981 (j) The commission shall adopt regulations for conducting cost and market impact
982 reviews and for administering this section. These regulations shall include definitions of
983 material change and non-material change, primary service areas, dispersed service areas,
984 dominant market share, materially higher prices and materially higher health status adjusted total
985 medical expenses, and any other terms as necessary. All regulations promulgated by the
986 commission shall comply with chapter 30A.

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

990 Section 14. (a) By January 1, 2014, the commission, in consultation with the office of
991 Medicaid, shall develop and implement standards of certification for patient-centered medical
992 homes. In developing these standards, the commission shall consider existing standards by the
993 National Committee for Quality Assurance or other independent accrediting and medical home

994 organizations. The standards developed by the commission shall be based on the following
995 criteria:

996 (1) enhancing access to routine care, urgent care and clinical advice through means such
997 as implementing shared appointments, open scheduling and after-hours care;

998 (2) enabling utilization of a range of qualified health care professionals, including
999 dedicated care coordinators, which may include, but not be limited to, nurse practitioners,
1000 physician assistants and social workers, in a manner that enables providers to practice to the
1001 fullest extent of their license;

1002 (3) encouraging shared decision-making for preference-sensitive conditions such as
1003 chronic back pain, early stage of breast and prostate cancers, hip osteoarthritis, and cataracts;
1004 provided that shared decision-making shall be conducted on, but not be limited to, long-term care
1005 and supports and palliative care; and

1006 (4) ensuring that patient-centered medical homes develop and maintain appropriate
1007 comprehensive care plans for their patients with complex or chronic conditions, including an
1008 assessment of health risks and chronic conditions.

1009 (5) such other criteria as the commission deems appropriate.

1010 In developing these standards, the commission shall consult with national and local
1011 organizations working on medical home models, relevant state agencies, health plans,
1012 physicians, nurse practitioners, behavioral health providers, hospitals, social workers, other
1013 health care providers and consumers. Furthermore, the commission shall consult with the

1014 department of public health to maximize opportunities for administrative simplification and
1015 regulatory consistency.

1016 (b) Nothing in this section shall be construed as prohibiting a primary care provider,
1017 behavioral health provider or specialty care provider from being certified as a patient-centered
1018 medical home; provided, that such providers meet the standards set by the commission in
1019 accordance with this section or are recognized by the National Committee for Quality Assurance
1020 as a patient-centered medical home.

1021 (c) Certification as a patient-centered medical home is voluntary. Primary care providers,
1022 behavioral health providers and specialty care providers certified by the commission as a patient-
1023 centered medical home shall renew their certification every 2 years under like terms.

1024 (d) A primary care provider or specialty care provider certified as a patient-centered
1025 medical home shall have the ability to assess and provide or arrange for, and coordinate care
1026 with, mental health and substance abuse services, to the extent determined by the commission. A
1027 behavioral health provider or specialty care provider certified as a patient-centered medical home
1028 shall have the ability to assess and provide or arrange for, and coordinate care with, primary care
1029 services, to the extent determined by the commission.

1030 (e) By July 1, 2014, the commission, in consultation with the office of Medicaid, shall
1031 establish a patient-centered medical home training for patient-centered medical homes to learn
1032 the core competencies of the patient-centered medical home model. The commission may require
1033 participation in such training as a condition of certification.

1034 (f) For continued certification by the commission under this section, the commission may
1035 establish and monitor specific quality standards. Such quality standards shall be developed with
1036 reference to the standard quality measure set established by section 14 of chapter 12C.

1037 (g) In providing after-hours care, a patient-centered medical home may enter into a
1038 cooperative agreement with another patient-centered medical home, primary care practice,
1039 limited service clinic, as defined by the department of public health, Medicare-certified home
1040 health agency for those patients that receive home-health services, or urgent care center to
1041 provide after-hours care for their patients.

1042 (h) The commission shall develop a model payment system for patient-centered medical
1043 homes certified under this section or recognized by the National Committee for Quality
1044 Assurance as a patient-centered medical home. In developing the model payment system, the
1045 commission shall consider, but not be limited to, per-patient payments, payment levels based on
1046 care-complexity, and payments for care coordination, clinical management, quality performance
1047 and shared savings. Development of the model patient-centered medical home payment system
1048 shall be completed by January 1, 2014.

1049 (i) Payers may make patient-centered medical home payments to network providers
1050 certified as a patient-centered medical home under this section or recognized by the National
1051 Committee for Quality Assurance as a patient-centered medical home, or equivalent. Payers may
1052 use the model payment system developed by the commission or any other medical home
1053 payment system the carrier deems appropriate.

1054 (j) The commission shall develop and distribute a directory of key existing referral
1055 systems and resources that can assist patients in obtaining housing, food, transportation, child

care, elder services, long-term care services, peer services and other community-based services. This directory shall be made available to patient-centered medical homes in order to connect patients to services in their community.

(k) Nothing in this section shall preclude the continuation of existing patient-centered medical homes or medical home programs currently operating or under development.

Section 15. (a) The commission shall establish a process for certain registered provider organizations to be certified as accountable care organizations, herein referred to as ACOs; provided that no provider organization is required to become an ACO. The ACO shall be certified for a term of 2 years and renewable under like terms. The purpose of the ACO certification process shall be to encourage the adoption of integrated delivery care systems in the commonwealth for the purpose of cost containment, quality improvement and patient protection. The commission shall create a common application form for provider organizations that wish to apply to the commission. Within 30 days of an application submission, the commission may require the applicant to provide additional information.

(b) The commission shall establish minimum standards for certified ACOs. A certified ACO shall: (i) be organized or registered as a separate legal entity from its ACO participants; (ii) have a governance structure that includes an administrative officer, a medical officer, and patient or consumer representation; (iii) receive reimbursements or compensation from alternative payment methodologies; (iv) have functional capabilities to coordinate financial payments amongst its providers; (v) have significant implementation of interoperable health information technology, as determined by the commission, for the purposes of care delivery coordination and population management; (vi) develop and file an internal appeals plan as

required for risk-bearing provider organizations under section 24 of chapter 176O; provided, that said plan shall be approved by the office of patient protection; provided further, that the plan shall be a part of a membership packet for newly enrolled individuals; (vii) provide medically necessary services across the care continuum including behavioral and physical health services, as determined by the commission through regulations, internally or through contractual agreements; provided, that any medically necessary service that is not internally available shall be provided to a patient through services outside the ACO; (viii) implement systems that allow ACO participants to report the pricing of services, as defined by the commission through regulations; further provided that ACO participants shall have the ability to provide patients with relevant price information when contemplating their care and potential referrals; (ix) obtain a risk certificate from the division of insurance under chapter 176U; and (x) shall engage patients in shared decision-making, including, but not limited to, shared-decision making on palliative care and long-term care services and supports.

(c) The commission may establish additional standards for an ACO. In developing additional standards for ACO certification, the commission shall consider the following goals for ACOs:

(1) to reduce the growth of health status adjusted total medical expenses over time, consistent with the state's efforts to meet the health care cost growth benchmark established under section 9;

(2) to improve the quality of health services provided, as measured by the statewide quality measure set and other appropriate measures, as established by the commission;

1099 (3) to ensure patient access to health care services across the care continuum, including,
1100 but not limited to, access to: preventive and primary care services; emergency services;
1101 hospitalization services; ambulatory patient services; mental health, substance use disorder and
1102 behavioral health services; access to specialty care units, including, but are not limited to, burn,
1103 coronary care, cancer care, including the services of a comprehensive cancer center, neonatal
1104 care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical,
1105 including trauma and intensive care units; pediatric services; obstetrics and gynecology services;
1106 diagnostic imaging and screening services; clinical laboratory and pathology services; maternity
1107 and newborn care services and related mental health outcomes; radiation therapy and treatment
1108 services; skilled nursing facilities; family planning services; home health services; treatment and
1109 prevention services for alcohol and other drug abuse; breakthrough technologies and treatments;
1110 allied health services including, but not limited to, advance practice nurses, optometric care,
1111 direct access to chiropractic services and physical therapy, occupational therapists, dental care,
1112 midwifery services, and end-of-life care services, including hospice and palliative care; and
1113 establishing mechanisms to protect patient provider choice, including parameters for out-of-ACO
1114 arrangements;

1115 (4) to promote alternative payment methodologies consistent with the standards
1116 developed by the commission and the adoption of payment incentives that improve quality and
1117 care coordination, including, but not limited to, incentives to reduce avoidable hospitalizations,
1118 avoidable readmissions, adverse events and unnecessary emergency room visits; incentives to
1119 reduce racial, ethnic and linguistic health disparities in the patient population; and in all cases
1120 ensuring that alternative payment methodologies do not create any incentive to deny or limit

1121 medically necessary care, especially for patients with high risk factors or multiple health
1122 conditions;

1123 (5) to improve access to certain primary care services, including, but not limited to, by
1124 having a demonstrated primary care and care coordination capacity and a minimum number of
1125 practices engaged in becoming patient centered medical homes including certified patient
1126 centered medical homes;

1127 (6) to improve access to health care services and quality of care for vulnerable
1128 populations including, but not limited to, children, the elderly, low-income individuals,
1129 individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities,
1130 including demonstrating an ability to provide culturally and linguistically appropriate care,
1131 patient education and outreach provided by community health workers.

1132 (7) to promote the integration of mental health, substance use disorder and behavioral
1133 health services with primary care services including, but not limited to, the establishment of
1134 behavioral health medical homes, recovery coaching and peer support and services provided by
1135 peer support workers, certified peer specialists and licensed alcohol and drug counselors;

1136 (8) to promote patient-centeredness by, including, but not limited to, establishing
1137 mechanisms to conduct patient outreach and education on the necessity and benefits of care
1138 coordination, including group visits and chronic disease self-management programs;
1139 demonstrating an ability to effectively involve patients in care transitions to improve the
1140 continuity and quality of care across settings, with case manager follow up; demonstrating an
1141 ability to engage and activate patients at home, through methods such as home visits or
1142 telemedicine, to improve self-management; establishing mechanisms to evaluate patient

1143 satisfaction with the access and quality of their care; establishing mechanisms between payers
1144 and the provider organization such that any shared savings between the provider and the payer
1145 shall contain a mechanism to return a percentage of the savings to the ACO patients; and
1146 establishing mechanisms to protect patient provider choice, including parameters for accessing
1147 care outside of the ACO;

1148 (9) to adopt certain health information technology, data analysis functions and
1149 performance management programs, including, but not limited to, the ability to aggregate and
1150 analyze clinical data; the ability to electronically exchange patient summary records across
1151 providers who are ACO participants and other providers in the community to ensure continuity
1152 of care; the ability to provide access to multi-payer claims data and performance reports and the
1153 ability to share performance feedback on a timely basis with participating providers; the ability
1154 to enable the beneficiary access to electronic health information, provided that the patient has
1155 provided consent; and the utilization of a proven performance management program, including,
1156 but not limited to, participation in the 2011 and 2012 Health Care Criteria for Performance
1157 Excellence as developed in conjunction with the Baldrige Criteria for Performance Excellence
1158 administered by the National Institutes of Standards and Technology of the United States
1159 Department of Commerce;

1160 (10) to demonstrate excellence in the area of managing chronic disease and care
1161 coordination, as managed by a physician, nurse practitioner, registered nurse, physician assistant
1162 or social worker, and as evidenced by the success of previous or existing care coordination, pay
1163 for performance, patient centered medical home, quality improvement or health outcomes
1164 improvement initiatives, including, but not limited to, a demonstrated commitment to reducing
1165 avoidable hospitalizations, adverse events and unnecessary emergency room visits;

1166 (11) to promote protocols for provider integration, both with providers within and outside
1167 of the provider organization, including, but not limited to, clinical integration of the medical
1168 director of the laboratory, accredited or certified under the federal Clinical Laboratory
1169 Improvements Act of 1988, providing these services to the organization;

1170 (12) to promote community-based wellness programs and community health workers,
1171 consistent with efforts funded by the department of public health through the Prevention and
1172 Wellness Trust Fund established in section 2G of chapter 111 and to promote other activities that
1173 integrate community public health interventions with an emphasis on the social determinants of
1174 health and which have been proven to improve health;

1175 (13) to promote the health and well being of children, including, but not limited to,
1176 improving access to pediatric care, providing access to mental and behavioral health services for
1177 children, developing and improving pediatric quality measures, developing and improving on
1178 pediatric risk adjustments.

1179 (14) to promote worker training programs and skills training opportunities for employees
1180 of the provider organization, consistent with efforts funded by the secretary of labor and
1181 workforce development through the Health Care Workforce Transformation Trust Fund;

1182 (15) to adopt certain governance structure standards, including standards related to
1183 financial conflicts of interest and transparency; and

1184 (16) any other requirements the commission considers necessary.

1185 (d) The commission shall update the standards for certification as an ACO at least every
1186 2 years, or at such other times as the commission determines necessary. The commission shall

1187 not deny an ACO certification based solely on the geographic location or size of the provider
1188 organization.

1189 (e) The commission shall create a designation process for Model ACOs only to be
1190 conferred on ACOs that have demonstrated excellence in adopting the best practices for quality
1191 improvement, cost containment and patient protections, as determined by the commission. In
1192 developing this standard of excellence, the commission shall review the standards set forth in
1193 subsection (c).

1194 (f) All ACOs shall publish the standards used by the ACO to determine which providers
1195 of free-standing ancillary services shall be approved to provide services to ACO patients. Free-
1196 standing ancillary services shall include, but shall not be limited to, durable medical equipment
1197 services, laboratory services, imaging services, dialysis centers, and services provided by free-
1198 standing diagnostic, non-hospital surgery centers. A provider of these services shall be informed
1199 in writing by the ACO of the standards by which they were accepted or rejected as an approved
1200 provider of these free-standing ancillary services for ACO patients.

1201 The commission shall create a review process for aggrieved providers under this
1202 subsection that are denied approval by an ACO as a provider of free-standing ancillary services
1203 for ACO patients. For such process, the commission may review the following: (1) a comparison
1204 of the costs of services between an aggrieved provider and the costs of services provided within
1205 the ACO; (2) a comparison of the quality of services between an aggrieved provider and the
1206 quality of services provided within the ACO; (3) a comparison of the efficiency of services
1207 between an aggrieved provider and efficiency of services provided within the ACO; and (4) the

1208 extent to which the aggrieved provider meets the published standards used by the ACO to
1209 determine inclusion as an approved provider for ACO patients.

1210 (g) The commission shall promulgate any necessary regulations to administer this
1211 section. In promulgating such regulations, the regulations shall, to the extent applicable and
1212 feasible, be consistent with federal law, regulations, demonstrations and rules governing
1213 accountable care organizations and shared savings programs.

1214 Section 16. (a) There is hereby established within the commission an office of patient
1215 protection. The office shall:- (1) have the authority to administer and enforce the standards and
1216 procedures established by sections 13, 14, 15 and 16 of chapter 176O. The commission shall
1217 promulgate such regulations to enforce this section. Such regulations shall protect the
1218 confidentiality of any information about a carrier or utilization review organization, as defined in
1219 said chapter 176O, which, in the opinion of the office, and in consultation with the division of
1220 insurance, is proprietary in nature and is not in the public interest to disclose. Utilization review
1221 criteria, medical necessity criteria and protocols must be made available to the public at no
1222 charge regardless of proprietary claims. The regulations authorized by this section shall be
1223 consistent with, and not duplicate or overlap with, regulations promulgated by the bureau of
1224 managed care established in the division of insurance pursuant to said chapter 176O;

1225 (2) make managed care information collected by the office readily accessible to
1226 consumers on the commission's website. The information shall, at a minimum, include (i) a
1227 chart, prepared by the office, comparing the information obtained on premium revenue expended
1228 for health care services as provided under paragraph (3) of subsection (b) of section 7 of chapter

1229 176O, for the most recent year for which information is available, and (ii) data collected under
1230 paragraph (c);

1231 (3) assist consumers with questions or concerns relating to managed care, including, but
1232 not limited to, exercising the grievance and appeals rights established by sections 13 and 14 of
1233 said chapter 176O;

1234 (4) monitor quality-related health insurance plan information relating to managed care
1235 practices;

1236 (5) regulate the establishment and functions of review panels established by section 14 of
1237 chapter 176O;

1238 (6) periodically advise the commission, the commissioner of insurance, the managed care
1239 oversight board, established by section 16D of chapter 6A, the joint committee on health care
1240 financing and the joint committee on financial services on actions, including legislation, which
1241 may improve the quality of managed care health insurance plans;

1242 (7) administer and grant enrollment waivers under paragraph (4) of subsection (a) of
1243 section 4 of chapter 176J; provided, however, that the office of patient protection may grant a
1244 waiver to an eligible individual who certifies, under penalty of perjury, that such individual did
1245 not intentionally forego enrollment into coverage for which the individual is eligible and that is
1246 at least actuarially equivalent to minimum creditable coverage; provided further, that the office
1247 shall establish, by regulation, standards and procedures for enrollment waivers; and

1248 (8) establish, by regulation, procedures and rules relating to appeals by consumers
1249 aggrieved by restrictions on patient choice, denials of services or quality of care resulting from

1250 any final action of an ACO, and to conduct hearings and issue rulings on appeals brought by
1251 ACO consumers that are not otherwise properly heard through the consumer's payer or provider.

1252 (b) The commission shall establish an external review system for the review of
1253 grievances submitted by or on behalf of insureds of carriers under section 14 of chapter 176O.
1254 The commission shall establish an external review process for the review of grievances
1255 submitted by or on behalf of ACO patients and shall specify the maximum amount of time for
1256 the completion of a determination and review after a grievance is submitted. The commission
1257 shall establish expedited review procedures applicable to emergency situations, as defined by
1258 regulation promulgated by the division.

1259 (c) Each entity that compiles the health plan employer data and information set, so-called,
1260 for the National Committee on Quality Assurance, or collects other information deemed by the
1261 entity as similar or equivalent thereto, shall, upon submitting said data and information sent to
1262 the commission concurrently submit to the office of patient protection a copy thereof, excluding,
1263 at the entity's option, proprietary financial data.

1264 Section 17. The commission shall keep an accurate account of all its activities and of all
1265 its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal
1266 year to its board, to the governor, to the general court, and to the state auditor, such reports to be
1267 in a form prescribed by the board, with the written approval of the auditor. The auditor may
1268 investigate the affairs of the commission, may severally examine the properties and records of
1269 the commission, and may prescribe methods of accounting and of rendering of periodic reports
1270 in relation to projects undertaken by the commission. The commission shall be subject to
1271 biennial audit by the state auditor.

1272 Section 18. The commission may adopt regulations to implement this chapter.

1273 SECTION 16. The third sentence of subsection (c) of section 4R of chapter 7 of the
1274 General Laws, as inserted by section 15 of chapter 68 of the acts of 2011, is hereby amended by
1275 striking out the words “division of health care finance and policy” and inserting in place thereof
1276 the following words:- center for health information and analysis.

1277 SECTION 17. Section 22N of said chapter 7, as appearing in the 2010 Official Edition, is
1278 hereby amended by striking out, in lines 10 and 37, the word “118G” and inserting in place
1279 thereof, in each instance, the following word:- 118E.

1280 SECTION 18. Chapter 12 of the General Laws is hereby amended by inserting after
1281 section 11M the following section:-

1282 Section 11N. (a) The attorney general shall monitor trends in the health care market
1283 including, but not limited to, trends in provider organization size and composition, consolidation
1284 in the provider market, payer contracting trends and patient access and quality issues in the
1285 health care market. The attorney general may obtain the following information from a private
1286 health care payer, public health care payer, provider or provider organization, as those terms are
1287 defined in section 1 of chapter 6D: (i) any information that is required to be submitted under
1288 sections 8, 9 and 10 of chapter 12C, (ii) filings, applications and supporting documentation
1289 related to any cost and market impact review under section 13 of chapter 6D (iii) filings,
1290 applications and supporting documentation related to a determination of need application filed
1291 under section 25C of chapter 111; and (iv) filings, applications and supporting documentation
1292 submitted to the federal Centers for Medicare and Medicaid Services or the Office of the
1293 Inspector General for any demonstration project. Under section 17 of chapter 12C and section 8

of chapter 6D and subject to the limitations stated in those sections, the attorney general may require that any provider, provider organization, private health care payer or public health care payer produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends , the factors that contribute to cost growth within the commonwealth’s health care system and the relationship between provider costs and payer premium rates.

(b) The attorney general may investigate any provider organization referred to the attorney general by the health policy commission under section 13 of chapter 6D to determine whether the provider organization engaged in unfair methods of competition or anti-competitive behavior in violation of chapter 93A or any other law, and, if appropriate, take action under chapter 93A or any other law to protect consumers in the health care market.

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

(d) Nothing in this section shall limit the authority of the attorney general to protect consumers in the health care market under any other law.

SECTION 19. The General Laws are hereby further amended by inserting after chapter 12B the following chapter:-

Chapter 12C

1316 Center for Health Information and Analysis

1317 Section 1. As used in this chapter the following words shall, unless the context clearly
1318 requires otherwise, have the following meanings:-

1319 “Accountable care organization”, or “ACO”, a provider organization certified under
1320 section 15 of chapter 6D.

1321 “Actual costs”, all direct and indirect costs incurred by a hospital or a community health
1322 center in providing medically necessary care and treatment to its patients, determined in
1323 accordance with generally accepted accounting principles.

1324 “Acute hospital”, the teaching hospital of the University of Massachusetts Medical
1325 School and any hospital licensed under section 51 of chapter 111 and which contains a majority
1326 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of
1327 public health.

1328 “Alternative payment contract”, any contract between a provider or provider organization
1329 and a public health care payer or a private health care payer which utilizes alternative payment
1330 methodologies.

1331 “Alternative payment methodologies or methods”, methods of payment that are not solely
1332 based on fee-for-service reimbursements; provided, that “alternative payment methodologies”
1333 may include, but not be limited to, shared savings arrangement, bundled payments, and global
1334 payments; provided further, that “alternative payment methodologies” may include fee-for-
1335 service payments, which are settled or reconciled with a bundled or global payment.

1336 “Ambulatory surgical center”, any distinct entity that operates exclusively to provide
1337 surgical services to patients not requiring hospitalization and meets the requirements of the
1338 federal Health Care Financing Administration for participation in the Medicare program.

1339 “Ambulatory surgical center services”, services described for purposes of the Medicare
1340 program under 42 USC § 1395k(a)(2)(F)(I); provided, that “ambulatory surgical center services”
1341 shall include facility services only and shall not include surgical procedures.

1342 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health
1343 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
1344 176A; a nonprofit medical service corporation organized under chapter 176B; a health
1345 maintenance organization organized under chapter 176G; and an organization entering into a
1346 preferred provider arrangement under chapter 176I, but not including an employer purchasing
1347 coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or
1348 affiliated corporations of the employer; provided that, unless otherwise noted, the term “carrier”
1349 shall not include any entity to the extent it offers a policy, certificate or contract that provides
1350 coverage solely for dental care services or vision care services.

1351 “Case mix”, the description and categorization of a hospital’s patient population
1352 according to criteria approved by the center including, but not limited to, primary and secondary
1353 diagnoses, primary and secondary procedures, illness severity, patient age and source of
1354 payment.

1355 “Center”, the center for health information and analysis.

1356 “Charge”, the uniform price for specific services within a revenue center of a hospital.

1357 “Child”, a person who is under 18 years of age.

1358 “Clinical affiliation”, any relationship between a provider organization and another entity
1359 for the purpose of increasing the level of collaboration in the provision of health care services,
1360 including, but not limited to, sharing of physician resources in hospital or other ambulatory
1361 settings, co-branding, expedited transfers to advanced care settings, provision of inpatient
1362 consultation coverage or call coverage, enhanced electronic access and communication, co-
1363 located services, provision of capital for service site development, joint training programs, video
1364 technology to increase access to expert resources and sharing of hospitalists or intensivists.

1365 “Commission”, the health policy commission established in chapter 6D.

1366 “Community health centers”, health centers operating in conformance with Section 330
1367 of United States Public Law 95-626 and shall include all community health centers which file
1368 cost reports as requested by the center.

1369 “Dependent”, the spouse and children of any employee if such persons would qualify for
1370 dependent status under the Internal Revenue Code or for whom a support order could be granted
1371 under chapters 208, 209 or 209C.

1372 “Dispersed service area,” a geographic area of the commonwealth in which a provider
1373 organization delivers health care services; provided, however, that the center may by regulation
1374 establish standards to determine dispersed service areas based on the number of zip codes, towns,
1375 counties or primary service areas, which standards may vary based upon the population density
1376 of various regions of the commonwealth.

1377 “Eligible person”, a person who qualifies for financial assistance from a governmental
1378 unit in meeting all or part of the cost of general health supplies, care or rehabilitative services
1379 and accommodations.

1380 “Employee”, a person who performs services primarily in the commonwealth for
1381 remuneration for a commonwealth employer; provided, that “employee” shall not include a
1382 person who is self-employed.

1383 “Employer”, an employer as defined in section 1 of chapter 151A.

1384 “Executive director”, the executive director of the center.

1385 “Facility”, a licensed institution providing health care services or a health care setting,
1386 including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical
1387 or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory
1388 and imaging centers, and rehabilitation and other therapeutic health settings.

1389 “Fee-for-service”, a payment mechanism in which all reimbursable health care activity is
1390 described and categorized into discreet and separate units of service and each provider is
1391 separately reimbursed for each discrete service rendered to a patient.

1392 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
1393 ends in the calendar year by which it is identified.

1394 “General health supplies, care or rehabilitative services and accommodations”, all
1395 supplies, care and services of medical, behavioral health, substance use disorder, mental health,
1396 optometric, dental, surgical, chiropractic, podiatric, psychiatric, therapeutic, diagnostic,
1397 rehabilitative, supportive or geriatric nature, including inpatient and outpatient hospital care and

1398 services, and accommodations in hospitals, sanatoria, infirmaries, convalescent and nursing
1399 homes, retirement homes, facilities established, licensed or approved under chapter 111B and
1400 providing services of a medical or health-related nature, and similar institutions including those
1401 providing treatment, training, instruction and care of children and adults; provided, however, that
1402 rehabilitative service shall include only rehabilitative services of a medical or health-related
1403 nature which are eligible for reimbursement under Title XIX of the Social Security Act.

1404 “Governmental unit”, the commonwealth, any department, agency board or commission
1405 of the commonwealth and any political subdivision of the commonwealth.

1406 “Gross patient service revenue”, the total dollar amount of a hospital’s charges for
1407 services rendered in a fiscal year.

1408 “Health care professional”, a physician or other health care practitioner licensed,
1409 accredited, or certified to perform specified health services consistent with law.

1410 “Health care cost growth benchmark”, the projected annual percentage change in total
1411 health care expenditures in the commonwealth, as established in section 9 of chapter 6D.

1412 “Health care services”, supplies, care and services of medical, behavioral health,
1413 substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic,
1414 psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature
1415 including, but not limited to, inpatient and outpatient acute hospital care and services; services
1416 provided by a community health center or by a sanatorium, as included in the definition of
1417 “hospital” in Title XVIII of the federal Social Security Act, and treatment and care compatible
1418 with such services or by a health maintenance organization.

1419 “Health insurance company”, a company as defined in section 1 of chapter 175 which
1420 engages in the business of health insurance.

1421 “Health insurance plan”, the medicare program or an individual or group contract or other
1422 plan providing coverage of health care services and which is issued by a health insurance
1423 company, a hospital service corporation, a medical service corporation or a health maintenance
1424 organization.

1425 “Health maintenance organization”, a company which provides or arranges for the
1426 provision of health care services to enrolled members in exchange primarily for a prepaid per
1427 capita or aggregate fixed sum as further defined in section 1 of chapter 176G.

1428 “Health status adjusted total medical expenses”, the total cost of care for the patient
1429 population associated with a provider group based on allowed claims for all categories of
1430 medical expenses and all non-claims related payments to providers, adjusted by health status,
1431 and expressed on a per member per month basis, as calculated under section 9 and the
1432 regulations promulgated by the center.

1433 “Hospital”, any hospital licensed under section 51 of chapter 111, the teaching hospital of
1434 the University of Massachusetts Medical School and any psychiatric facility licensed under
1435 section 19 of chapter 19.

1436 “Hospital service corporation”, a corporation established to operate a nonprofit hospital
1437 service plan as provided in chapter 176A.

1438 “Major service category,” a set of service categories to be established by regulation,
1439 which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii)

1440 outpatient and ambulatory services, by categories as defined by the Centers for Medicare and
1441 Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all
1442 other” outpatient and ambulatory services that do not fall within a defined category; (iii)
1443 behavioral, substance use disorder and mental health services by categories as defined by the
1444 Centers for Medicare and Medicaid, or as established by regulation; (iv) professional services, by
1445 categories as defined by the Centers for Medicare and Medicaid, or as established by regulation;
1446 and (v) sub-acute services, by major service line or clinical offering, as defined by regulation.

1447 “Medicaid program”, the medical assistance program administered by the division of
1448 medical assistance under chapter 118E and in accordance with Title XIX of the Federal Social
1449 Security Act or any successor statute.

1450 “Medical assistance program”, the medicaid program, the Veterans Administration health
1451 and hospital programs and any other medical assistance program operated by a governmental
1452 unit for persons categorically eligible for such program.

1453 “Medical service corporation”, a corporation established to operate a nonprofit medical
1454 service plan as provided in chapter 176B.

1455 “Medicare program”, the medical insurance program established by Title XVIII of the
1456 Social Security Act.

1457 “Net cost of private health insurance”, the difference between health premiums earned
1458 and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as
1459 included in medical loss ratio regulations promulgated by the division of insurance; (ii) net
1460 additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise
1461 defined by regulations promulgate by the center.

1462 “Network contract”, a contract entered between a provider or provider organization and a
1463 carrier or third-party administrator concerning payment for the provision of health care services.

1464 “Non-acute hospital”, any hospital which is not an acute hospital.

1465 “Patient”, any natural person receiving health care services.

1466 “Patient-centered medical home”, a model of health care delivery designed to provide a
1467 patient with a single point of coordination for all their health care, including primary, specialty,
1468 post-acute and chronic care, which is (i) patient-centered; (ii) comprehensive, integrated and
1469 continuous; and (iii) delivered by a team of health care professionals to manage a patient’s care,
1470 reduce fragmentation, and improve patient outcomes.

1471 “Primary service area”, a geographic area of the commonwealth in which consumers are
1472 likely to travel to obtain health services; provided, however, that the center may by regulation
1473 establish standards to determine primary service areas by major service category, which
1474 standards may vary based upon the population density of various regions of the commonwealth.

1475 “Private health care payer”, a carrier authorized to transact accident and health insurance
1476 under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a
1477 nonprofit medical service corporation licensed under chapter 176B, a dental service corporation
1478 organized under chapter 176E, an optometric service corporation organized under chapter 176F,
1479 a self-insured plan, to the extent allowable under federal law governing health care provided by
1480 employers to employees, or a health maintenance organization licensed under chapter 176G.

1481 “Provider”, any person, corporation partnership, governmental unit, state institution or
1482 any other entity qualified under the laws of the commonwealth to perform or provide health care
1483 services.

1484 “Provider organization”, any corporation, partnership, business trust, association or
1485 organized group of persons, which is in the business of health care delivery or management,
1486 whether incorporated or not that represents 1 or more health care providers in contracting with
1487 carriers for the payments of health care services, including but not limited to, physician
1488 organizations, physician-hospital organizations, independent practice associations, provider
1489 networks, accountable care organizations and any other organization that contracts with carriers
1490 for payment for health care services.

1491 “Public health care payer”, the Medicaid program established in chapter 118E; any
1492 carrier or other entity that contracts with the office of Medicaid or the commonwealth health
1493 insurance connector to pay for or arrange the purchase of health care services on behalf of
1494 individuals enrolled in health coverage programs under Titles XIX or XXI, or under the
1495 commonwealth care health insurance program, including prepaid health plans subject to the
1496 provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission
1497 established under chapter 32A; and any city or town with a population of more than 60,000 that
1498 has adopted chapter 32B.

1499 “Purchaser”, a natural person responsible for payment for health care services rendered
1500 by a hospital.

1501 “Quality measures”, the standard quality measure set as defined by the center in section
1502 14.

1503 “Registered provider organization,” a provider organization that has been registered in
1504 accordance with section 11 of chapter 6D.

1505 “Relative prices”, the contractually negotiated amounts paid to providers by each private
1506 and public carrier for health care services, including non-claims related payments and expressed
1507 in the aggregate relative to the payer’s network-wide average amount paid to providers, as
1508 calculated under section 9 and regulations promulgated by the center.

1509 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
1510 patient for a charge.

1511 “Resident”, a person living in the commonwealth, as defined by the center by regulation;
1512 provided, however, that such regulation shall not define a resident as a person who moved into
1513 the commonwealth for the sole purpose of securing health insurance under this chapter; and
1514 provided, further that confinement of a person in a nursing home, hospital or other medical
1515 institution shall not, in and of itself, suffice to qualify such person as a resident.

1516 “Secretary”, the secretary of health and human services.

1517 “Self-employed”, a person who, at common law, is not considered to be an employee and
1518 whose primary source of income is derived from the pursuit of a bona fide business.

1519 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
1520 business, which is not a health insurance plan, and in which the business is liable for the actual
1521 costs of the health care services provided by the plan and administrative costs.

1522 “Self-insured group”, a self-insured or self-funded employer group health plan.

1523 “Specialty hospital”, an acute hospital which qualifies for an exemption from the
1524 medicare prospective payment system regulations or any acute hospital which limits its
1525 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to
1526 children or patients under obstetrical care.

1527 “State institution”, any hospital, sanatorium, infirmary, clinic and other such facility
1528 owned, operated or administered by the commonwealth, which furnishes general health supplies,
1529 care or rehabilitative services and accommodations.

1530 “Surcharge payor”, an individual or entity that pays for or arranges for the purchase of
1531 health care services provided by acute hospitals and ambulatory surgical center services provided
1532 by ambulatory surgical centers; provided, however, that the term “surcharge payor” shall include
1533 a managed care organization; and provided further, that “surcharge payor” shall not include Title
1534 XVIII and Title XIX programs and their beneficiaries or recipients, other governmental
1535 programs of public assistance and their beneficiaries or recipients and the workers’ compensation
1536 program established under chapter 152.

1537 “Third party administrator”, an entity that administers payments for health care services
1538 on behalf of a client in exchange for an administrative fee.

1539 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX
1540 programs, other governmental payers, insurance companies, health maintenance organizations
1541 and nonprofit hospital service corporations; provided, that, “third party payer” shall not include a
1542 purchaser responsible for payment for health care services rendered by a hospital, either to the
1543 purchaser or to the hospital.

1544 “Title XIX”, Title XIX of the Social Security Act, 42 USC 1396 et seq., or any successor
1545 statute enacted into federal law for the same purposes as Title XIX.

1546 “Total health care expenditures”, the annual per capita sum of all health care expenditures
1547 in the commonwealth from public and private sources, including: (i) all categories of medical
1548 expenses and all non-claims related payments to providers, as included in the health status
1549 adjusted total medical expenses reported by the center under subsection (d) of section 8; (ii) all
1550 patient cost-sharing amounts, such as deductibles and copayments; and (iii) the net cost of
1551 private health insurance, or as otherwise defined in regulations promulgated by the center.

1552 Section 2. There is hereby established a center for health information and analysis. There
1553 shall be in the center an executive director, who shall be the administrative head of the center and
1554 who shall be appointed by a majority vote of the attorney general, the state auditor and the
1555 governor for a term of 5 years. The person so appointed shall be selected without regard to
1556 political affiliation and solely on the basis of expertise in health care policy, expertise in health
1557 care finance and such other educational requirements and experience that the attorney general,
1558 state auditor and governor determine are necessary.

1559 In the case of a vacancy in the position of executive director, a successor shall be
1560 appointed in the same manner as the original appointment for the unexpired term. No person
1561 shall be appointed for more than 2 consecutive 5-year terms.

1562 The person so appointed may be removed from office, for cause, by a majority vote of the
1563 attorney general, the state auditor and the governor. Such cause may include substantial neglect
1564 of duty, gross misconduct or conviction of a crime. The reasons for removal of the executive
1565 director shall be stated in writing and shall include the basis for such removal. The writing shall

1566 be sent to the clerk of the senate, the clerk of the house of representative and to the governor at
1567 the time of the removal and shall be a public record.

1568 Section 3. The executive director may appoint and remove, subject to appropriation, such
1569 agents and subordinate officers and employees as the executive director may consider necessary
1570 and may establish such subdivisions within the center as the executive director considers
1571 appropriate to fulfill the following duties: (i) to collect, analyze and disseminate health care
1572 information to assist in the formulation of health care policy and in the provision and purchase of
1573 health care services including, but not limited to, collecting, storing and maintaining data in a
1574 payer and provider claims database; (ii) to provide an analysis of health care spending trends as
1575 compared to the health care cost growth benchmark established by the health policy commission
1576 under section 9 of chapter 6D; (iii) to collect, analyze and disseminate information regarding
1577 providers, provider organizations and payers to increase the transparency and improve the
1578 functioning of the health care system; (iv) to provide information to, and work with, the general
1579 court and other state agencies including, but not limited to, the executive office of health and
1580 human services, the department of public health, the department of mental health, the health care
1581 policy commission, the office of Medicaid and the division of insurance to collect and
1582 disseminate data concerning the cost, price and functioning of the health care system in the
1583 commonwealth and the health status of individuals; (v) to participate in and provide data and
1584 data analysis for annual hearings conducted by the health policy commission concerning health
1585 care provider and payer costs, prices and cost trends; and (vi) report to consumers comparative
1586 health care cost and quality information through the consumer health information website
1587 established under section 20. The center shall make available actual costs and prices of health

1588 care services, as supplied by each provider, to the general public in a conspicuous manner on the
1589 consumer health information website.

1590 Section 4. The position of executive director shall be classified under section 45 of
1591 chapter 30 and the salary shall be determined under section 46C of said chapter 30.

1592 The total amount of all appointee salaries shall not exceed the sum appropriated therefor
1593 by the general court. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E
1594 shall not apply to the executive director of the center. Sections 45, 46 and 46C of chapter 30
1595 shall not apply to any employee of the center.

1596 The executive director may establish personnel regulations for the officers and employees
1597 of the center. The executive director shall file an annual personnel report not later than the first
1598 Wednesday in February with the senate and house committees on ways and means containing the
1599 job classifications, duties and salary of each officer and employee within the center together with
1600 personnel regulations applicable to said officers and employees. The executive director shall file
1601 amendments to such report with the senate and house committees on ways and means whenever
1602 any changes become effective.

1603 Section 5. The center shall adopt and amend rules and regulations, in accordance with
1604 chapter 30A, for the administration of its duties and powers and necessary to effectuate this
1605 chapter; provided, however, that the rules or regulations shall not be construed to impair or in
1606 any way modify the authority of the executive office of health and human services to act,
1607 pursuant to section 16 of chapter 6A of the General Laws, as the single state agency authorized
1608 to supervise and administer the state programs under titles XIX and XXI of the Social Security
1609 Act. The regulations shall be adopted, after notice and hearing, only upon consultation with

1610 representatives of providers, provider organizations, private health care payers and public health
1611 care payers.

1612 The center shall, before adopting regulations under this chapter, consult with other
1613 agencies of the commonwealth and the federal government, affected providers, and affected
1614 payers, as applicable, to ensure that the reporting requirements imposed under the regulations are
1615 not duplicative or excessive. If reporting requirements imposed by the center result in additional
1616 costs for the reporting providers, these costs may be included in any rates promulgated by the
1617 executive office of health and human services or a governmental unit designated by the executive
1618 office for these providers. The center may specify categories of information which may be
1619 furnished under an assurance of confidentiality to the provider; provided, however, that such
1620 assurance shall only be furnished if the information is not to be used for setting rates.

1621 Section 6. In addition to the powers conferred on state agencies, the center shall have the
1622 following powers:

1623 (1) to make, amend and repeal rules and regulations for the management of its affairs;

1624 (2) to make contracts and execute all instruments necessary or convenient for the carrying
1625 on of its business;

1626 (3) to acquire, own, hold, dispose of and encumber personal property and to lease real
1627 property in the exercise of its powers and the performance of its duties; and

1628 (4) to enter into agreements or transactions with any federal, state or municipal agency or
1629 other public institution or with any private individual, partnership, firm, corporation, association
1630 or other entity.

Section 7. Each acute hospital, ambulatory surgical center and surcharge payor shall pay to the commonwealth an amount for the estimated expenses of the center.

The assessed amount for hospitals and ambulatory surgical centers shall be not less than 33 per cent of the amount appropriated by the general court for the expenses of the center minus amounts collected from (1) filing fees; (2) fees and charges generated by the center's publication or dissemination of reports and information; and (3) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Each acute hospital and ambulatory surgical center shall pay the assessed amount multiplied by the ratio of the hospital's or ambulatory surgical center's gross patient service revenues to the total of all such hospital's and ambulatory surgical center's gross patient services revenues. Each acute hospital and ambulatory surgical center shall make a preliminary payment to the center on October 1 of each year in an amount equal to $\frac{1}{2}$ of the previous year's total assessment. Thereafter, each hospital and ambulatory surgical center shall pay, within 30 days notice from the center, the balance of the total assessment for the current year based upon its most current projected gross patient service revenue. The center shall subsequently adjust the assessment for any variation in actual and estimated expenses of the center and for changes in hospital or ambulatory surgical center gross patient service revenue. The estimated and actual expenses shall include an amount equal to the cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D of chapter 29. In the event of late payment by any such hospital or ambulatory surgical center, the treasurer shall advance the amount of due and unpaid funds to the center before the receipt of the monies in anticipation of the revenues up to the amount authorized in the then current budget attributable to the assessments and the center shall reimburse the

1653 treasurer for the advances upon receipt of the revenues. This section shall not apply to any state
1654 institution or to any acute hospital which is operated by a city or town.

1655 The assessed amount for surcharge payors shall be not less than 33 per cent of the amount
1656 appropriated by the general court for the expenses of the center minus amounts collected from
1657 (1) filing fees; (2) fees and charges generated by the center's publication or dissemination of
1658 reports and information; and (3) federal matching revenues received for these expenses or
1659 received retroactively for expenses of predecessor agencies. The assessment on surcharge
1660 payors shall be calculated and collected in the same manner as the assessment authorized under
1661 section 68 of chapter 118E.

1662 Section 8. (a) The center shall promulgate such regulations as necessary to ensure the
1663 uniform reporting of revenues, charges, costs, prices, and utilization of health care services and
1664 other such data as the center may require of institutional providers and their parent organizations
1665 and any other affiliated entities, non-institutional providers and provider organizations; provided,
1666 however, that the center may establish reporting thresholds through regulation. Such uniform
1667 reporting shall enable the center to identify, on a patient-centered and provider-specific basis,
1668 statewide and regional trends in the cost, price, availability and utilization of medical, surgical,
1669 diagnostic and ancillary services provided by acute hospitals, nursing homes, chronic care and
1670 rehabilitation hospitals, other specialty hospitals, clinics, including mental health clinics and the
1671 ambulatory care providers as the center may specify. The center shall also promulgate
1672 regulations to require providers to report any agreements through which 1 provider agrees to
1673 furnish another provider with a discount, rebate or any other type of refund or remuneration in
1674 exchange for, or in any way related to, the provision of health care services.

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

(c) The center shall also collect and analyze such data as it considers necessary in order to better protect the public's interest in monitoring the financial conditions of acute hospitals. The information shall be analyzed on an industry-wide and hospital-specific basis and shall include, but not be limited to: (1) gross and net patient service revenues; (2) sources of hospital revenue, including revenue excluded from consideration in the establishment of hospital rates and charges under section 13G of chapter 118E; (3) private sector charges; (4) trends in inpatient and outpatient case mix, payer mix, hospital volume and length of stay; (5) total payroll as a per cent of operating expenses, as well as the salary and benefits of the top 10 highest compensated employees, identified by position description and specialty; and (6) other relevant measures of financial health or distress.

1698 The center shall publish annual reports and establish a continuing program of
1699 investigation and study of financial trends in the acute hospital industry, including an analysis of
1700 systemic instabilities or inefficiencies that contribute to financial distress in the acute hospital
1701 industry. The reports shall include an identification and examination of hospitals that the center
1702 considers to be in financial distress, including any hospitals at risk of closing or discontinuing
1703 essential health services, as defined by the department of public health under section 51G of
1704 chapter 111, as a result of financial distress.

1705 The center may modify uniform reporting requirements established under subsections (a)
1706 and (b) and may require hospitals to report required information quarterly to effectuate this
1707 subsection.

1708 (d) The center shall publicly report and place on its website information on health status
1709 adjusted total medical expenses including a breakdown of the health status adjusted total medical
1710 expenses by major service category and by payment methodology, relative prices and hospital
1711 inpatient and outpatient costs, including direct and indirect costs under this chapter on an annual
1712 basis; provided, however, that at least 10 days before the public posting or reporting of provider
1713 specific information the affected provider shall be provided the information for review. The
1714 center shall request from the federal Centers for Medicare and Medicaid Services the health
1715 status adjusted total medical expenses of provider groups that serve Medicare patients.

1716 (e) When collecting information or compiling reports intended to compare individual
1717 health care providers, the center shall require that:

1718 (1) providers which are representative of the target group for profiling shall be
1719 meaningfully involved in the development of all aspects of the profile methodology, including
1720 collection methods, formatting and methods and means for release and dissemination;

1721 (2) the entire methodology for collecting and analyzing the data shall be disclosed
1722 to all relevant provider organizations and to all providers under review;

1723 (3) data collection and analytical methodologies shall be used that meet accepted
1724 standards of validity and reliability;

1725 (4) the limitations of the data sources and analytic methodologies used to develop
1726 provider profiles shall be clearly identified and acknowledged, including, but not limited to, the
1727 appropriate and inappropriate uses of the data;

1728 (5) to the greatest extent possible, provider profiling initiatives shall use standard-
1729 based norms derived from widely accepted, provider-developed practice guidelines;

1730 (6) provider profiles and other information that have been compiled regarding
1731 provider performance shall be shared with providers under review prior to dissemination;
1732 provided, however, that opportunity for corrections and additions of helpful explanatory
1733 comments shall be provided prior to publication; and, provided, further, that such profiles shall
1734 only include data which reflect care under the control of the provider for whom such profile is
1735 prepared;

1736 (7) comparisons among provider profiles shall adjust for patient case-mix and
1737 other relevant risk factors and control for provider peer groups, when appropriate;

1738 (8) effective safeguards to protect against the unauthorized use or disclosure of
1739 provider profiles shall be developed and implemented;

1740 (9) effective safeguards to protect against the dissemination of inconsistent,
1741 incomplete, invalid, inaccurate or subjective profile data shall be developed and implemented;
1742 and

1743 (10) the quality and accuracy of provider profiles, data sources and methodologies
1744 shall be evaluated regularly.

1745 Section 9. (a) The center shall promulgate regulations to require that provider
1746 organizations registered under section 11 of chapter 6D report the data as it considers necessary
1747 in order to better protect the public's interest in monitoring the financial conditions,
1748 organizational structure, business practices and market share of each registered provider
1749 organization. The center may assess administrative fees on provider organizations in an amount
1750 to help defray the center's costs in complying with this section. The center may specify in
1751 regulations uniform reporting standards and reporting thresholds as it determines necessary.

1752 (b) The center shall require registered provider organizations to report following
1753 information annually: (1) organizational charts showing the ownership, governance and
1754 operational structure of the provider organization, including any clinical affiliations and
1755 community advisory boards; (2) the number of affiliated health care professional full-time
1756 equivalents by license type, specialty, name and address of principal practice location and
1757 whether the professional is employed by the organization; (3) the name and address of licensed
1758 facilities by license number, license type and capacity in each major service category; (4) a
1759 comprehensive financial statement, including information on parent entities and corporate

1760 affiliates as applicable, and including details regarding annual costs, annual receipts, realized
1761 capital gains and losses, accumulated surplus and accumulated reserves; (5) information on stop-
1762 loss insurance and any non-fee-for-service payment arrangements; (6) information on clinical
1763 quality, care coordination and patient referral practices; (7) information regarding expenditures
1764 and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-
1765 taxes and other non-clinical functions; (8) information regarding charitable care and community
1766 benefit programs; (9) for any risk-bearing provider organization, certificate from the division of
1767 insurance under chapter 176U; and (10) such other information as the center considers
1768 appropriate as set forth in the center's regulations; provided, however, that the center shall
1769 coordinate with the commission and the division of insurance to obtain information directly from
1770 the commission and the division of insurance where available. The center may, in consultation
1771 with the division of insurance and the commission, merge similar reporting requirements where
1772 appropriate.

1773 (c) Annual reporting shall be in a form provided by the center. The center shall
1774 promulgate regulations that define criteria for waivers from certain annual reporting
1775 requirements of this section. Criteria for waivers may include operational size of the provider
1776 organization, the provider organization's annual net patient service revenue, the degree of risk
1777 assumed by the provider organization, and other criteria as the center considers appropriate.

1778 (d) Notwithstanding the annual reporting requirements of this section, the commission
1779 may require in writing, at any time, additional information reasonable and necessary to
1780 determine the financial condition, organizational structure, business practices or market share of
1781 a registered provider organization.

Section 10.(a) The center shall promulgate regulations necessary to ensure the uniform reporting of information from private and public health care payers, including third-party administrators, that enables the center to analyze: (1) changes over time in health insurance premium levels; (2) changes in the benefit and cost-sharing design of plans offered by these payers; (3) changes in measures of plan cost and utilization; provided that this analysis shall facilitate comparison among plans and between public and private payers; and (4) changes in type of payment methods implemented by payers and the number of members covered by alternative payment methodologies; provided, however, that this analysis shall facilitate comparison among plans and plan types, including the self-insured. The center shall adopt regulations to require private and public health care payers to submit claims data, member data and provider data to develop and maintain a database of health care claims data under this chapter.

(b) The center shall require the submission of data and other information from each private health care payer offering small or large group health plans including, but not limited to: (1) average annual individual and family plan premiums for each payer's most popular plans for a representative range of group sizes, as further determined in regulations, and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (2) information concerning the actuarial assumptions that underlie the premiums for each plan; (3) summaries of the plan and network designs for each plan, including whether behavioral, substance use disorder and mental health or other specific services are carved-out from any plans; (4) information concerning the medical and administrative expenses, including medical loss ratios for each plan, using a uniform methodology and collected under section 21 of

chapter 176O; (5) information concerning the payer's current level of reserves and surpluses; (6) information on provider payment methods and levels; (7) health status adjusted total medical expenses by registered provider organization, provider group and local practice group and zip code calculated according to the method established under section 51 of chapter 288 of the acts of 2010; (8) relative prices paid to every hospital, registered provider organization, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider, with hospital inpatient and outpatient prices listed separately and product type, including health maintenance organization and preferred provider organization products and determined using the method established under section 52 of chapter 288 of the acts of 2010; (9) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology; (10) the annual rate of growth, stated as a percentage, of the average relative price by provider type and product type for the payer's participating health care providers, whether that rate exceeds the rate of growth of the applicable producer price index as reported by the United States Bureau of Labor Statistics and identified by the commissioner of insurance and whether that rate exceeds the rate of growth in projected economic growth benchmark established under section 7H½ of chapter 29; and (11) a comparison of relative prices for the payer's participating health care providers by provider type which shows the average relative price, the extent of variation in price, stated as a percentage, and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the average relative price.

(c) The center shall require the submission of data and other information from public health care payers including, but not limited to: (1) average premium rates for health insurance

1828 plans offered by public payers and information concerning the actuarial assumptions that
1829 underlie these premiums; (2) average annual per-member per-month payments for enrollees in
1830 MassHealth primary care clinician and fee for service programs; (3) summaries of plan and
1831 network designs for each plan or program, including whether behavioral, substance use disorder
1832 and mental health or other specific services are carved-out from any plans; (4) information
1833 concerning the medical and administrative expenses, including medical loss ratios for each plan
1834 or program; (5) where appropriate, information concerning the payer's current level of reserves
1835 and surpluses; (6) information on provider payment methods and levels, including information
1836 concerning payment levels to each hospital for the 25 most common medical procedures
1837 provided to enrollees in these programs, in a form that allows payment comparisons between
1838 Medicaid programs and managed care organizations under contract to the office of Medicaid; (7)
1839 health status adjusted total medical expenses by registered provider organization, provider group
1840 and local practice group and zip code calculated according to the method established under
1841 section 51 of chapter 288 of the acts of 2010; and (8) relative prices paid to every hospital,
1842 registered provider organization, physician group, ambulatory surgical center, freestanding
1843 imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home
1844 health provider in the payer's network, by type of provider, with hospital inpatient and outpatient
1845 prices listed separately, and product type and determined using the method established under
1846 section 52 of chapter 288 of the acts of 2010; (9) hospital inpatient and outpatient costs,
1847 including direct and indirect costs, according to a uniform methodology; () the annual rate of
1848 growth, stated as a percentage, of the average relative price by provider type and product type
1849 for the payer's participating health care providers, whether that rate exceeds the rate of growth of
1850 the applicable producer price index as reported by the United States Bureau of Labor Statistics

and identified by the commissioner of insurance and whether that rate exceeds the rate of growth in projected economic growth benchmark established under section 7H½ of chapter 29; and (11) a comparison of relative prices for the payer's participating health care providers by provider type which shows the average relative price, the extent of variation in price, stated as a percentage and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the average relative price.

(d) The center shall require the submission of data and other information from public and private health care payers which utilize alternative payment contracts, including, but not limited to: (1) if applicable, the negotiated monthly or yearly budget for each alternative payment contract in the current contract year; (2) any applicable measures of provider performance in such alternative payment contracts; and (3) if applicable, the average negotiated monthly or yearly budget weighted by member months for each geographic region of the commonwealth as further defined in regulations promulgated by the center.

For purposes of this subsection, payers shall report the negotiated budget assuming a neutral health status score of 1.0 using an industry accepted health status adjustment tool and shall, if applicable, separately report the budget allowances for: all medical and behavioral, substance use disorder and mental health care at both in and out-of-network providers; pharmacy coverage allowance; administrative expenses such as data analytics, health information technology, clinical program development and other program management fees; the purchase of reinsurance or stop-loss; and quality bonus monies, unit cost adjustments or other special allowances as may be required in regulations promulgated by the center. If out-of-network care, behavioral, substance use disorder and mental health, stop-loss insurance or any other clinical

1874 services are carved out of any global budget, bundled payments or other alternative payment
1875 methodologies such that there is no allowance included in the budget for those services, payers
1876 shall report actual claims costs of these items on a per member per month basis for the year
1877 immediately prior to the current contract year.

1878 (e) Except as specifically provided otherwise by the center or under this chapter, insurer
1879 data collected by the center under this section shall not be a public record under clause Twenty-
1880 sixth of section 7 of chapter 4 or under chapter 66.

1881 Section 11. The center shall ensure the timely reporting of information required under
1882 sections 8, 9 and 10. The center shall notify payers, providers and provider organizations of any
1883 applicable reporting deadlines. The center shall notify, in writing, a private health care payer,
1884 provider or provider organization, which has failed to meet a reporting deadline and that failure
1885 to respond within 2 weeks of the receipt of the notice may result in penalties. The center may
1886 assess a penalty against a private payer, provider or provider organization that fails, without just
1887 cause, to provide the requested information within 2 weeks following receipt of the written
1888 notice required under this paragraph, of up to \$1,000 per week for each week of delay after the 2
1889 week period following the private payer's, provider's or provider organization's receipt of the
1890 written notice; provided, however, that the maximum annual penalty against a private payer,
1891 provider or provider organization under this section shall be \$50,000. Amounts collected under
1892 this section shall be deposited in the Healthcare Payment Reform Fund, established under section
1893 100 of 194 of the acts of 2011.

1894 Section 12. (a) The center shall be the sole repository for health care data collected under
1895 sections 8, 9 and 10. The center shall collect, store and maintain such data in a payer and

1896 provider claims database. The center shall acquire, retain and oversee all information technology,
1897 infrastructure, hardware, components, servers and employees necessary to carry out this section.
1898 All other agencies, authorities, councils, boards and commissions of the commonwealth seeking
1899 health care data that is collected under this section shall, whenever feasible, utilize the data
1900 before requesting data directly from health care providers and payers. In order to ensure patient
1901 data confidentiality, the center shall not contract or transfer the operation of the database or its
1902 functions to a third-party entity, nonprofit organization or governmental entity; provided,
1903 however, that the center may enter into interagency services agreements for transfer and use of
1904 the data.

1905 The center shall, to the extent feasible, make data in the payer and provider claims
1906 database available to payers and providers in real-time; provided, however, that all data-sharing
1907 complies with applicable state and federal privacy laws The center may charge a fee for access to
1908 the data.

1909 To the maximum extent feasible, the center shall also make data available to health care
1910 consumers, on a timely basis and in an easily readable and understandable format, data on health
1911 care services they have personally received.

1912 (b) The center shall permit providers, provider organizations, public and private health
1913 care payers, government agencies and authorities and researchers access to de-identified data
1914 collected by the center for the purposes of lowering total medical expenses, coordinating care,
1915 benchmarking, quality analysis and other research, administrative or planning purposes,
1916 provided, however, that the data shall not include information that would allow the identification
1917 of the health information of an individual patient, except to the extent necessary for a

government agency or authority to accomplish the public purposes for which access was given. The center shall also permit providers, provider organizations, and public and private health care payers access to data with patient identifiers solely for the purpose of carrying out treatment and coordinating care among providers. Access to data authorized under this section shall be deemed to comply with the requirements of chapter 66A. The center shall charge user fees sufficient to defray the center's cost of providing such access to non-governmental entities.

Section 13. The center shall coordinate with the public health council and the boards of registration for health care providers to develop a uniform and interoperable electronic system of public reporting for providers as a condition of licensure. The uniform provider licensure reporting system shall include information designed for health resource planning and for analysis of market share by provider organization by primary service areas and dispersed service areas, including, but not limited to, reporting for each licensed provider its principal business locations; the categories of services provided; the provider organization with which the provider is affiliated for contracting purposes, or by which the provider is employed, if any; whether and to what extent the provider is practicing on license; and other factors as the center considers appropriate. The center may centralize the uniform provider licensure reporting system or create a central portal for public access to the uniform provider licensure information. The uniform provider licensure reporting system shall be accessible to other state agencies and authorities including, but not limited to, the commission, the executive office of health and human services, the department of public health and the office of Medicaid.

Section 14. (a) The center shall develop the uniform reporting of a standard set of health care quality measures for each health care provider facility, medical group, or provider group in the commonwealth hereinafter referred to as the "standard quality measure set."

(b) The center shall convene a statewide advisory committee which shall recommend to the center a standard quality measure set. The statewide advisory committee shall consist of the executive director of the center or designee, who shall serve as the chairperson; the executive director of the group insurance commission or designee, the Medicaid director or designee; and 7 representatives of organizations to be appointed by the governor, 1 of whom shall be a representative from an acute care hospital or hospital association, 1 of whom shall be a representative from a provider group or medical association or provider association, 1 of whom shall be a representative from a medical group, 2 of whom shall be representatives of private health plans, 1 of whom shall be a representative from an employer association and 1 of whom shall be a representative from a health care consumer group.

(c) In developing its recommendation of the standard quality measure set, the advisory committee shall, after consulting with state and national organizations that monitor and develop quality and safety measures, select from existing quality measures and shall not select quality measures that are still in development or develop its own quality measures. The committee shall annually recommend to the center any updates to the standard quality measure set on or before November 1. The committee may solicit for consideration and recommend other nationally recognized quality measures, including, but not limited to, recommendations from medical or provider specialty groups as to appropriate quality measures for that group's specialty. At a minimum, the standard quality measure set shall consist of the following quality measures: (1) the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention; (2) the Hospital Consumer Assessment of Healthcare Providers and Systems survey; (3) the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted

1964 aggregate of the individual measures by medical or provider group; and (4) the Ambulatory Care
1965 Experiences Survey. The standard quality measure set shall include outcome measures. The
1966 committee shall review additional appropriate outcome measures as they are developed.

1967 Section 15. (a) For the purposes of this section, the following words shall, unless the
1968 context clearly requires otherwise, have the following meanings:

1969 “Adverse event”, injury to a patient resulting from a medical intervention and not to the
1970 underlying condition of the patient.

1971 “Board”, the patient safety and medical errors reduction board.

1972 “Lehman center”, the Betsy Lehman center for patient safety and medical error reduction.

1973 “Incident”, an incident which, if left undetected or uncorrected, might have resulted in an
1974 adverse event.

1975 “Medical error”, the failure of medical management of a planned action to be completed
1976 as intended or the use of a wrong plan to achieve an outcome.

1977 “Patient safety”, freedom from accidental injury.

1978 (b) There shall be established within the center the Betsy Lehman center for patient safety
1979 and medical error reduction. The purpose of the Lehman center shall be to serve as a
1980 clearinghouse for the development, evaluation and dissemination, including, but not limited to,
1981 the sponsorship of training and education programs, of best practices for patient safety and
1982 medical error reduction. The Lehman center shall: (1) coordinate the efforts of state agencies
1983 engaged in the regulation, contracting or delivery of health care and those individuals or
1984 institutions licensed by the commonwealth to provide health care to meet their responsibilities

1985 for patient safety and medical error reduction; (2) assist all such entities to work as part of a total
1986 system of patient safety; and (3) develop appropriate mechanisms for consumers to be included
1987 in a statewide program for improving patient safety. The Lehman center shall coordinate state
1988 participation in any appropriate state or federal reports or data collection efforts relative to
1989 patient safety and medical error reduction. The Lehman center shall analyze available data,
1990 research and reports for information that would improve education and training programs that
1991 promote patient safety.

1992 (c) Within the Lehman center, there shall be established a patient safety and medical
1993 errors reduction board. The board shall consist of the secretary of health and human services, the
1994 executive director of the center, the director of consumer affairs and business regulations and the
1995 attorney general. The board shall appoint, in consultation with the advisory committee, the
1996 director of the Lehman center by a unanimous vote and the director shall, under the general
1997 supervision of the board, have general oversight of the operation of the Lehman center. The
1998 director may appoint or retain and remove expert, clerical or other assistants as the work of the
1999 Lehman center may require. The coalition for the prevention of medical errors shall serve as the
2000 advisory committee to the board. The advisory committee shall, at the request of the director,
2001 provide advice and counsel as it considers appropriate including, but not limited to, serving as a
2002 resource for studies and projects undertaken or sponsored by the Lehman center. The advisory
2003 committee may also review and comment on regulations and standards proposed or promulgated
2004 by the Lehman center, but the review and comment shall be advisory in nature and shall not be
2005 considered binding on the Lehman center.

2006 (d) The Lehman center shall develop and administer a patient safety and medical error
2007 reduction education and research program to assist health care professionals, health care facilities

2008 and agencies and the general public regarding issues related to the causes and consequences of
2009 medical error and practices and procedures to promote the highest standard for patient safety in
2010 the commonwealth. The Lehman center shall annually report to the governor and the general
2011 court relative to the feasibility of developing standards for patient safety and medical error
2012 reduction programs for any state department, agency, commission or board to reduce medical
2013 errors, and the statutory responsibilities of the commonwealth, for the protection of patients and
2014 consumers of health care together with recommendations to improve coordination and
2015 effectiveness of the programs and activities.

2016 (e) The Lehman center shall (1) identify and disseminate information about evidence-
2017 based best practices to reduce medical errors and enhance patient safety; (2) develop a process
2018 for determining which evidence-based best practices should be considered for adoption; (3) serve
2019 as a central clearinghouse for the collection and analysis of existing information on the causes of
2020 medical errors and strategies for prevention; and (4) increase awareness of error prevention
2021 strategies through public and professional education. The information collected by the Lehman
2022 center or reported to the Lehman center shall not be a public record as defined in section 7 of
2023 chapter 4, shall be confidential and shall not be subject to subpoena or discovery or introduced
2024 into evidence in any judicial or administrative proceeding, except as otherwise specifically
2025 provided by law.

2026 (f) The Lehman center shall report annually to the general court regarding the progress
2027 made in improving patient safety and medical error reduction. The Lehman center shall seek
2028 federal and foundation support to supplement state resources to carry out the Lehman center's
2029 patient safety and medical error reduction goals.

Section 16. (a) The center shall publish an annual report based on the information submitted under sections 8, 9 and 10 concerning health care provider, provider organization and private and public health care payer costs and cost trends, section 13 of chapter 6D relative to market power reviews and section 15 relative to quality data. The center shall compare the costs and cost trends with the health care cost growth benchmark established by the health policy commission under section 9 of chapter 6D, analyzed by regions of the commonwealth, and shall detail: (1) baseline information about cost, price, quality, utilization and market power in the commonwealth's health care system; (2) cost growth trends for care provided within and outside of accountable care organizations and patient-centered medical homes; (3) cost growth trends by provider sector, including but not limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices and durable medical equipment; (4) factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates; (5) the proportion of health care expenditures reimbursed under fee-for-service and alternative payment methodologies; (6) the impact of health care payment and delivery reform efforts on health care costs including, but not limited to, the development of limited and tiered networks, increased price transparency, increased utilization of electronic medical records and other health technology; (7) the impact of any assessments including, but not limited to, the health system benefit surcharge collected under section 68 of chapter 118E, on health insurance premiums; (8) trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging and other high-cost services; (9) the prevalence and trends in adoption of alternative payment methodologies and impact of alternative payment methodologies on overall health care spending, insurance premiums and provider rates; (10) the development and status of provider organizations in the

2053 commonwealth including, but not limited to, acquisitions, mergers, consolidations and any
2054 evidence of excess consolidation or anti-competitive behavior by provider organizations; and
2055 (11) the impact of health care payment and delivery reform on the quality of care delivered in the
2056 commonwealth.

2057 As part of its annual report, the center shall report on price variation between health care
2058 providers, by payer and provider type. The center's report shall include: (1) baseline information
2059 about price variation between health care providers by payer including, but not limited to,
2060 identifying providers or provider organizations that are paid more than 10 per cent above or more
2061 than 10 per cent below the average relative price and identifying payers which have entered into
2062 alternative payment contracts that vary by more than 10 per cent; (2) the annual change in price
2063 variation, by payer, among the payer's participating providers; (3) factors that contribute to price
2064 variation in the commonwealth's health care system; (4) the impact of price variations on
2065 disproportionate share hospitals and other safety net providers; and (5) the impact of health
2066 reform efforts on price variation including, but not limited to, the impact of increased price
2067 transparency, increased prevalence of alternative payment contracts and increased prevalence of
2068 accountable care organizations and patient centered medical homes.

2069 The center shall publish and provide the report to health policy commission at least 30
2070 days before any hearing required under section 8 of chapter 6D. The center may contract with an
2071 outside organization with expertise in issues related to the topics of the hearings to produce this
2072 report.

2073 (b) The center shall participate in the annual hearing required by section 8 of chapter 6D
2074 and advise and assist the health policy commission in conducting such hearing including, but not

2075 limited to, identifying witnesses and examining and cross-examining providers, provider
2076 organizations and payers regarding any issues material to the subject of such hearings.

2077 (c) The center shall provide technical assistance to the health policy commission in
2078 compiling the annual report required by section 8 of chapter 6D including, but not limited to,
2079 providing access to any data collected by the center under section 8, 9 and 10 and providing
2080 analysis regarding spending trends and factors underlying the spending trends.

2081 Section 17. The attorney general may review and analyze any information submitted to
2082 the center under sections 8, 9 and 10 and the health policy commission under section 8 of chapter
2083 6D. The attorney general may require that any provider, provider organization, or payer produce
2084 documents, answer interrogatories and provide testimony under oath related to health care costs
2085 and cost trends, factors that contribute to cost growth within the commonwealth's health care
2086 system and the relationship between provider costs and payer premium rates. The attorney
2087 general shall keep confidential all nonpublic information and documents obtained under this
2088 section and shall not disclose the information or documents to any person without the consent of
2089 the provider or payer that produced the information or documents except in a public hearing
2090 under section 8 of chapter 6D, a rate hearing before the division of insurance or in a case brought
2091 by the attorney general, if the attorney general believes that such disclosure will promote the
2092 health care cost containment goals of the commonwealth and that the disclosure should be made
2093 in the public interest after taking into account any privacy, trade secret or anti-competitive
2094 considerations. The confidential information and documents shall not be public records and shall
2095 be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of
2096 chapter 66.

2097 Section 18. The center shall perform ongoing analysis of data it receives under sections 8,
2098 9 and 10 to identify any payers, providers or provider organizations whose increase in health
2099 status adjusted total medical expense is considered excessive and who threaten the ability of the
2100 state to meet the health care cost growth benchmark established by the health care finance and
2101 policy commission under section 10 of chapter 6D. The center shall confidentially provide a list
2102 of the payers, providers and provider organizations to the health policy commission such that the
2103 authority may pursue further action under section 10 of chapter 6D.

2104 Section 19. The center shall review and comment upon all capital expenditure projects
2105 requiring a determination of need under section 25C of chapter 111, including, but not limited to,
2106 the availability and accessibility of services similar to those provided, or proposed to be
2107 provided, through the provider organization within its primary service areas and dispersed
2108 service areas; the provider organization's impact on competing options for the delivery of health
2109 care services within its primary service areas and dispersed service areas; less costly or more
2110 effective alternative financing methods for the projects; the immediate and long-term financial
2111 feasibility of the projects; the probable impact of the project on costs of and charges for services;
2112 and the availability of funds for capital and operating needs. The center may transmit to the
2113 department of public health its written recommendations on each project. The center shall
2114 appear and comment on any application for a determination of need where a public hearing is
2115 required under said section 25C of said chapter 111.

2116 Section 20. (a) The center, in consultation with commission, the executive office of
2117 health and human services, the department of public health and such other agencies or authorities
2118 as it deems appropriate, shall maintain a consumer health information website. The website shall
2119 contain information comparing the quality, price and cost of health care services. The website

2120 shall also provide information about provider and payer achievement of cost benchmarks and
2121 growth goals. The website may also contain general health care information as the center
2122 considers appropriate. The website shall be designed to assist consumers in making informed
2123 decisions regarding their medical care and informed choices among health care providers.
2124 Information shall be presented in a format that is understandable to the average consumer. The
2125 center shall publicize the availability of its website.

2126 (b) The website shall provide updated information on a regular basis, at least annually,
2127 and additional comparative quality, price and cost information shall be published as determined
2128 by the center. To the extent possible, the website shall include: (1) comparative price and cost
2129 information for the most common referral or prescribed services, as determined by the center,
2130 categorized by payer and listed by facility, provider, and provider organization or other
2131 groupings, as determined by the center ; (2) comparative quality information, as determined by
2132 the center, available by facility, provider, provider organization or any other provider grouping,
2133 as determined by the center, for each such service or category of service for which comparative
2134 price and cost information is provided; (3) general information related to each service or
2135 category of service for which comparative information is provided; (4) comparative quality
2136 information, as determined by the center, available by facility, provider, provider organization or
2137 other groupings, as determined by the center, that is not service-specific, including information
2138 related to patient safety and satisfaction; (5) data concerning healthcare-associated infections and
2139 serious reportable events reported under section 51H of chapter 111; (6) definitions of common
2140 health insurance and medical terms, including, but not limited to, those determined under
2141 sections 2715(g)(2) and (3) of the Public Health Service Act, so that consumers may compare
2142 health coverage and understand the terms of their coverage; (7) a list of health care provider

types, including but not limited to primary care physicians, nurse practitioners and physician assistants, and what types of services they are authorized to perform in the commonwealth under applicable state and federal scope of practice laws; (8) factors consumers should consider when choosing an insurance product or provider group, including, but not limited to, provider network, premium, cost-sharing, covered services, and tiering; (9) patient decision aids, which are interactive, written or audio-visual tools that provide a balanced presentation of the condition and treatment or screening options, benefits and harms, with attention to the patient's preferences and values, and which may facilitate conversations between patients and their health care providers about preference-sensitive conditions or diseases such as chronic back pain, early stage of breast and prostate cancers, hip osteoarthritis, and cataracts; provided, however, that decision aids shall be made available on, but not be limited to, long-term care and supports and palliative care; (10) a list of provider services that are physically and programmatically accessible for people with disabilities; and (11) descriptions of standard quality measures, as determined by the center.

(c) The center shall develop and adopt, on an annual basis, a reporting plan specifying the quality and cost measures to be included on the consumer health information website and the security measures used to maintain confidentiality and preserve the integrity of the data. In developing the reporting plan, the center, to the extent possible, shall collaborate with other organizations or state or federal agencies that develop, collect and publicly report health care quality and cost measures and the center shall give priority to those measures that are already available in the public domain. As part of the reporting plan, the center shall determine for each service the comparative information to be included on the consumer health information website.

(d) In designing and maintaining the website, the center may conduct research regarding ease of use of the website by health care consumers, consult with organizations that represent

health care consumers, and conduct focus groups that represent a cross section of health care consumers in the commonwealth, including low income consumers and consumers with limited literacy. The website shall comply with the Americans with Disabilities Act.

Section 21. The center shall establish a continuing program of investigation and study of the uninsured and underinsured in the commonwealth, including the health insurance needs of the residents of the geographically isolated or rural areas of the commonwealth. Said continuing investigation and study shall examine the overall impact of programs developed by the center and the division of medical assistance on the uninsured, the underinsured and the role of employers in assisting their employees in affording health insurance.

Section 22. (a) Any provider of health care services that receives reimbursement or payment for treatment of injured workers under chapter 152 and any provider of health care services other than an acute or non-acute hospital that receives reimbursement or payment from any governmental unit for general health supplies, care and rehabilitative services and accommodations, shall, as a condition of such reimbursement or payment: (1) permit the executive director, or the executive director's designated representative and the attorney general or a designee, to examine such books and accounts as may reasonably be required for the center to perform its duties; (2) file with the executive director from time to time or on request, such data, statistics, schedules or other information as the center may reasonably require, including outcome data and such information regarding the costs, if any, of the provider for research in the basic biomedical or health delivery areas or for the training of health care personnel which are included in the provider's charges to the public for health care services, supplies and accommodations; and (3) accept reimbursement or payment at the rates established by the secretary of health and human services or a governmental unit designated by the executive

2189 office, subject to a right of appeal under section 13E of chapter 118E, as discharging in full any
2190 and all obligations of an eligible person and the governmental unit to pay, reimburse or
2191 compensate the provider of health care services in any way for general health supplies, care and
2192 rehabilitative services or accommodations provided.

2193 (b) Any provider of health care services that knowingly fails to file with the center data,
2194 statistics, schedules or other information required under this section or by any regulation
2195 promulgated by the center or knowingly falsifies the same shall be punished by a fine of not less
2196 than \$100 nor more than \$500.

2197 (c) If, upon application by the center or its designated representative, the superior court
2198 upon summary hearing determines that a provider of health care services has, without justifiable
2199 cause, refused to permit any examination or to furnish information, as required in this section; it
2200 shall issue an order directing all governmental units to withhold payment for general health
2201 supplies, care and rehabilitative services and accommodations to such provider of services until
2202 further order of the court.

2203 (d) In addition, the appropriate licensing authority may suspend or revoke, after an
2204 adjudicatory proceeding under chapter 30A, the license of any provider of health care services
2205 that knowingly fails to file with the center data, statistics, schedules or other information required
2206 by this section or by any regulation of the center or that knowingly falsifies the same.

2207 SECTION 20. Section 18 of chapter 15A of the General Laws, as appearing in the 2010
2208 Official Edition, is hereby amended by striking out, in line 14 and in line 36, the words “division
2209 of health care finance and policy”, each time they appear, and inserting in place thereof, in each
2210 instance, the following words:- commonwealth health insurance connector.

2211 SECTION 21. Section 8H of chapter 26 of the General Laws, as so appearing, is hereby
2212 amended by striking out, in lines 60, 64, 71 and 72 and 73 and 74 the words “division of health
2213 care finance and policy”, each time they appear, and inserting in place thereof, in each instance,
2214 the following words:- center for health information and analysis.

2215 SECTION 22. Said section 8H of said chapter 26, as so appearing, is hereby further
2216 amended by striking out, in lines 55, 56, 77 and 78 the words “uncompensated care pool under
2217 section 18 of chapter 118G” and inserting in place thereof, in each instance, the following
2218 words:- health safety net under chapter 118E .

2219 SECTION 23. Chapter 26 of the General Laws is hereby amended by inserting after
2220 section 8J, as so appearing, the following section:-

2221 Section 8K. The commissioner of insurance may implement and enforce applicable
2222 provisions of the federal Mental Health Parity and Addiction Equity Act, section 511 of Public
2223 Law 110-343, and applicable state mental health parity laws, including section 22 of chapter
2224 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and
2225 sections 4, 4B and 4M of chapter 176G of the General Laws, in regard to any carrier licensed
2226 under chapters 175, 176A, 176B and 176G.

2227 SECTION 24. Section 2000 of chapter 29 of the General Laws, as so appearing, is
2228 hereby amended by striking out, in line 6, the words “18B of chapter 118G” and inserting in
2229 place thereof the following words:- 18 of chapter 176Q.

2230 SECTION 25. Said section 2000 of said chapter 29, as so appearing, is hereby further
2231 amended by striking out, in line 16, the words “established by section 18 of chapter 118G”.

2232 SECTION 26. Section 2PPP of said chapter 29, as so appearing, is hereby amended by
2233 striking out, in lines 16 and 17, the words “section 35 of chapter 118G” and inserting in place
2234 thereof the following words:- section 65 of chapter 118E.

2235 SECTION 27. Section 2RRR of said chapter 29, as so appearing, is hereby amended by
2236 striking out clauses (a) to (c), inclusive, and inserting in place thereof the following 2 clauses:-
2237 (a) any federal financial participation received by the commonwealth as a result of expenditures
2238 funded by such assessments, and (b) any interest thereon.

2239 SECTION 28. Said chapter 29 is hereby further amended striking out section 2FFFF,
2240 inserted by section 60 of chapter 139 of the acts of 2012 and inserting in place thereof the
2241 following section:-

2242 Section 2FFFF. There is hereby established and set up on the books of the
2243 commonwealth a separate fund to be known as the Health Care Workforce Transformation Fund,
2244 hereinafter called the fund. The fund shall be administered by the secretary of labor and
2245 workforce development in consultation with the Health Care Workforce Advisory Board,
2246 established in subsection (b) ; The secretary shall make expenditures from the Health Care
2247 Workforce Transformation Fund, without further appropriation; provided, however, that not
2248 more than 10 per cent of the amount held in the fund in any 1 year shall be used by the secretary
2249 for the combined cost of program administration, technical assistance to grantees and program
2250 evaluation. The secretary may contract with any appropriate entity to administer the fund or any
2251 portion therein.

2252 (b) There shall be a Health Care Workforce Trust Fund Advisory Board constituted to
2253 make recommendations to the director secretary concerning the administration and allocation of
2254 the fund and establishing evaluation criteria.

2255 The board shall consist of the following members: the secretary of labor and workforce
2256 development who shall serve as chairperson; the executive director of the commission or a
2257 designee; the commissioner of public health or a designee, and no more than 13 members who
2258 shall be appointed by the secretary and who shall reflect a broad distribution of diverse
2259 perspectives on the health care system and health care workforce needs, including health care
2260 providers, health care payers, health care employers, labor organizations, educational
2261 institutions, and consumer representatives.

2262 (c) The comptroller shall annually transfer not less than 20 per cent of available funds in
2263 the fund to the department of public health, without requiring the approval of the secretary of
2264 labor and workforce development, to be expended on the following programs:

2265 (1) The health care workforce loan repayment program, established under section
2266 25N of chapter 111, as administered by the healthcare workforce center;

2267 (2) The primary care residency grant program, established under section 25N $\frac{1}{2}$
2268 of chapter 111;

2269 (3) a primary care workforce development and loan forgiveness grant program at
2270 community health centers, established under section 25N $\frac{3}{4}$ of chapter 111.

2271 The secretary may also designate up to 10 per cent of available funds to be transferred by
2272 the comptroller to the Massachusetts Nursing and Allied Health Workforce Development Trust

2273 Fund established in section 33 of chapter 305 of the acts of 2008 to develop and support
2274 strategies that increase the number of public higher education faculty members and students who
2275 participate in programs that support careers in fields related to nursing and allied health. The
2276 secretary shall only designate funds for this purpose to the extent that the Massachusetts Nursing
2277 and Allied Health Workforce Development Trust Fund does not receive adequate funding in the
2278 annual appropriations bill approved by the general court.

2279 (d) Remaining monies from the fund shall be expended on programs that have 1 or more
2280 of the following purposes, with a focus on aligning expenditures with industry needs:

2281 (1) support the development and implementation of programs to enhance health
2282 care worker retention rates;

2283 (2) address critical health care workforce shortages;

2284 (3) improve employment in the health care industry for low-income individuals
2285 and low-wage workers;

2286 (4) provide training, educational, or career ladder services for currently employed
2287 or unemployed health care workers who are seeking new positions or responsibilities within the
2288 health care industry;

2289 (5) provide training or educational services for health care workers in emerging
2290 fields of care delivery models; or

2291 (6) fund rural health rotation programs, rural health clerkships, and rural health
2292 preceptorships at medical and nursing schools to expose students to practicing in rural and small
2293 town communities.

2294 (e) The secretary shall establish a competitive grant process for funds expended on
2295 programs under subsection (d). Eligible applicants shall include: employers and employer
2296 associations; local workforce investment boards; labor organizations; joint labor-management
2297 partnerships; community-based organizations; institutions of higher education; vocational
2298 education institutions; one-stop career centers; local workforce development entities; and any
2299 partnership or collaboration between eligible applicants. Expenditures from the fund for such
2300 purposes shall complement and not replace existing local, state, private, or federal funding for
2301 training and educational programs. All approved activities funded through the fund shall support
2302 the commonwealth's efforts to meet the health care cost growth benchmark established under
2303 section 9 of chapter 6D.

2304 (f) A grant proposal submitted under subsection (e) shall include, but not be limited to:

2305 (1) a plan that defines specific goals for health care workforce training and
2306 educational improvements;

2307 (2) the evidence-based programs the applicant shall use to meet the goals;

2308 (3) a budget necessary to implement the plan, including a detailed description of
2309 any funding or in-kind contributions the applicant or applicants will be providing in support of
2310 the proposal;

2311 (4) any other private funding or private sector participation the applicant
2312 anticipates in support of the proposal; and

2313 (5) the anticipated number of individuals who would receive a benefit due to the
2314 implementation of the plan.

2315 Priority may be given to proposals that target areas of critical labor needs for the health
2316 care industry or that are projected to be critical labor needs of the health care industry in the near
2317 future, consistent with the state health plan developed under section 16T of chapter 6A.
2318 Priority may also be given to proposals that target geographic areas with specific health care
2319 workforce needs or that target geographic areas with unemployment levels higher than the state
2320 average. If no proposals were offered in areas of particular need, the secretary may provide
2321 technical assistance and planning grant funding directly to eligible applicants in order to develop
2322 grant proposals.

2323 The secretary shall, in consultation with the Health Care Workforce Advisory Board,
2324 develop guidelines for an annual review of the progress being made by each grantee. Each
2325 grantee shall participate in any evaluation or accountability process implemented by or
2326 authorized by the secretary.

2327 (g) There shall be credited to the fund all monies payable pursuant to (1) funds that are
2328 paid to the health care workforce loan repayment program, established under section 25N of
2329 chapter 111 as a result of a breach of contract and private funds contributed from other sources;
2330 and (2) any revenue from appropriations or other monies authorized by the general court and
2331 specifically designated to be credited to the fund, and any gifts, grants, private contributions,
2332 investment income earned on the fund's assets and all other sources. Money remaining in the
2333 fund at the end of a fiscal year shall not revert to the General Fund and shall be available for
2334 expenditure in the following fiscal year.

2335 (h) The fund shall supplement and not replace existing publically-financed health care
2336 workforce development programs.

(i) The secretary shall annually report on its strategy for administration and allocation of the fund, including relevant evaluation criteria, and short-term and long-term programmatic and policy recommendations to improve workforce performance, and on expenditures from fund. The report shall include, but shall not be limited to: (1) the revenue credited to the fund; (2) the amount of fund expenditures attributable to administrative costs; (3) an itemized list of the funds expended through the competitive grant process, loan repayment program, and primary care residency program, and a description of the grantee activities; and; (4) the results of the evaluation of the effectiveness of the activities funded through grants. The report shall be provided to the secretary of administration and finance, the chairpersons of the house and senate committees on ways and means, the joint committee on public health, the joint committee on health care financing and the joint committee on labor and workforce development and shall be posted on the executive office of labor and workforce development's website.

(j) The secretary center shall promulgate regulations necessary to carry out this section.

SECTION 29. Said chapter 29 is hereby further amended by inserting after section 2FFFF the following section:—

Section 2GGGG. (a) There shall be established and set upon the books of the commonwealth a separate fund to be known as the Distressed Hospital Trust Fund to be expended, without further appropriation, by the health policy commission. The fund shall consist public and private sources such as gifts, grants and donations, interest earned on such revenues and any funds provided from other sources.

The board of the health policy commission, as trustee, shall administer the fund and shall make expenditures from the fund consistent with this section; provided, however, that not more

2359 than 10 per cent of the amounts held in the fund in any 1 year shall be used by the commission
2360 for the combined cost of program administration, technical assistance to grantees or program
2361 evaluation.

2362 (b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall
2363 not revert to the General Fund and shall be available for expenditure in the following fiscal year.

2364 (c) All expenditures from the Distressed Hospital Trust Fund shall support the state's
2365 efforts to meet the health care cost growth benchmark established in section 9 of chapter 6D and
2366 shall be consistent with any activities funded by the e-Health Institute, the Healthcare Payment
2367 Reform Fund, and any delivery system transformation initiative funds authorized by the federal
2368 government. All expenditures shall have 1 or more of the following purposes: (1) to improve
2369 and enhance the ability of community hospitals to serve populations efficiently and effectively;
2370 (2) to advance the adoption of health information technology, including interoperable electronic
2371 health records systems; (3) to accelerate the ability to electronically exchange information with
2372 other providers in the community to ensure continuity of care; (4) to support infrastructure
2373 investments necessary for the transition to alternative payment methodologies, including
2374 technology investments in data analysis functions and performance management programs,
2375 including systems to promote provider price transparency, necessary to aggregate and analyze
2376 clinical data on a population level; (5) to aid in the development of care practices and other
2377 operational standards necessary for certification as an ACO under section 15 and 6D; and (6) to
2378 improve the affordability and quality of care.

2379 (d) The commission shall annually award a grant by a competitive grant process to
2380 qualified acute hospitals. To be eligible to receive a grant under this subsection, a qualified acute

2381 hospital shall not include: (1) any hospital that is a teaching hospital; (2) any hospital whose
2382 relative prices are above the statewide median relative price, as determined by the center for
2383 health information analysis; or, (3) a for-profit hospital or a hospital that is part of a for-profit
2384 hospital system.

2385 (e) A grant proposal submitted under subsection (d) shall include, but not be limited to:
2386 (1) a plan that defines specific goals for improving the efficiency and affordability of hospital
2387 care over a multi-year period; (2) the evidence-based programs the applicant shall use to meet
2388 the goals; (3) a budget necessary to implement the plan, including a detailed description of any
2389 funding or in-kind contributions the applicant or applicants will be providing in support of the
2390 proposal; (4) a plan for sustaining any investments after the expiration of grant funds; and (5)
2391 any other private funding or private sector participation the applicant anticipates in support of the
2392 proposal.

2393 In reviewing the grant applications, the commission shall consider, among other factors:
2394 (1) the financial health of the qualified acute hospital and the demonstrated need for investment,
2395 taking into account all resources available to the particular provider including the relationship or
2396 affiliation of the particular provider to a health care delivery system and the capacity of the
2397 system to provide financial support for the acute hospital; (2) the anticipated return on
2398 investment, as measured by improved health care coordination and a reduction in health care
2399 costs; (3) whether the investment will support innovative health care delivery and payment
2400 models as identified by the health care policy commission; and (4) geographic need and
2401 population need. In assessing financial health, the commission shall, in consultation with the
2402 center for health information and analysis, take into account days cash on hand, net working
2403 capital and earnings before income tax, payer mix, uncompensated care, and depreciation and

2404 amortization, and access to working capital. If the commission determines that no suitable
2405 proposals have been received, such that the specific needs remain unmet, the commission may
2406 work directly with qualified acute hospitals to develop grant proposals.

2407 (f) All approved grants shall contain a limit on the amount an acute hospital may spend
2408 on administrative or overhead spending related to the approved project, as determined by the
2409 commission.

2410 (g) Funding for all approved interoperable health information technology projects for
2411 qualified acute hospitals shall be prioritized from any available funds in the Distressed Hospital
2412 Trust Fund before any funds from the e-Health Institute Trust Fund may be utilized.

2413 (h) As a condition of an award, the commission may require a qualified hospital to agree
2414 to an independent financial and operational audit to recommend steps to increase sustainability
2415 and efficiency of the acute hospital.

2416 (i) The commission shall develop guidelines for an annual review of the progress being
2417 made by each grantee. Each grantee shall participate in any evaluation or accountability process
2418 implemented or authorized by the commission. In the event that any recipient of grant monies
2419 from this trust does not utilize funding in a manner consistent with the approved grant
2420 application, the recipient shall be required to repay to the commission all or some portion, as
2421 determined by the commission, of the grant funds previously provided to the recipient under this
2422 section.

2423 (j) The commission shall, annually on or before January 31, report on expenditures from
2424 the Distressed Hospital Trust Fund. The report shall include, but not be limited to: (1) the
2425 revenue credited to the fund; (2) the amount of fund expenditures attributable to the

2426 administrative costs of the commission; (3) an itemized list of the funds expended through the
2427 competitive grant process and a description of the grantee activities; and (4) the results of the
2428 evaluation of the effectiveness of the activities funded through grants. The report shall be
2429 provided to the chairpersons of the house and senate committees on ways and means and the
2430 joint committee on health care financing and shall be posted on the commission's website.

2431 (k) The commission shall promulgate regulations necessary to carry out this section.

2432 SECTION 30. Said chapter 29 is hereby further amended by inserting after section 7H
2433 the following section:-

2434 Section 7H ½. (a) As used in this section the following words shall, unless the context
2435 clearly requires otherwise, have the following meanings:

2436 "Actual economic growth benchmark," the actual annual percentage change in the per
2437 capita state's gross state product, as established by the secretary of administration and finance
2438 under subsection (c).

2439 "Growth rate of potential gross state product", the long-run average growth rate of the
2440 commonwealth's economy, excluding fluctuations due to the business cycle.

2441 (b) On or before January 15, the secretary of administration and finance shall meet with
2442 the house and senate committees on ways and means and shall jointly develop a growth rate of
2443 potential gross state product for the ensuing calendar year which shall be agreed to by the
2444 secretary and the committees. In developing a growth rate of potential gross state product the
2445 secretary and the committees, or subcommittees of the committees, may hold joint hearings on
2446 the economy of the commonwealth; provided, however, that in the first year of the term of office

2447 of a governor who has not served in the preceding year, the parties shall agree to the growth rate
2448 of potential gross state product k not later than January 31 of that year. The secretary and the
2449 committees may agree to incorporate this hearing into any consensus tax revenue forecast
2450 hearing held under section 5B. The growth rate of potential gross state product shall be included
2451 with the consensus tax revenue forecast joint resolution under said section 5B and placed before
2452 the members of the general court for their consideration. The joint resolution, if passed by both
2453 branches of the general court, shall establish the growth rate of potential gross state product to be
2454 used by the health policy commission to establish the health care cost growth benchmark under
2455 section 9 of chapter 6D.

2456 (c) Not later than September 15 of each year, the secretary shall report the actual
2457 economic growth benchmark for the previous calendar year, based on the best information
2458 available at the time. The information shall be provided to the health policy commission
2459 established under chapter 6D.

2460 SECTION 31. Section 1 of chapter 29D of the General Laws, as appearing in the 2010
2461 Official Edition, is hereby amended by striking out, in line 13, the words “25 and 26 of chapter
2462 118G” and inserting in place thereof the following words:- 63 of chapter 118E.

2463 SECTION 32. Section 3 of said chapter 29D, as so appearing, is hereby amended by
2464 striking out, in line 18, the words “25 and 26 of chapter 118G” and inserting in place thereof the
2465 following words:- 63 of chapter 118E.

2466 SECTION 33. Said section 3 of said chapter 29D, as so appearing, is hereby further
2467 amended by striking out, in line 22, the words “25 and 26 of said chapter 118G” and inserting in
2468 place thereof the following words:- 63 of said chapter 118E.

2469 SECTION 34. Section 2 of chapter 32A of the General Laws, as so appearing, is hereby
2470 amended by inserting after paragraph (h) the following paragraph:-

2471 (h 1/2) “Primary care provider”, a health care professional qualified to provide general
2472 medical care for common health care problems who; (1) supervises, coordinates, prescribes, or
2473 otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and
2474 (3) maintains continuity of care within the scope of practice.

2475 SECTION 35. Section 22 of said chapter 32A, as so appearing, is hereby amended by
2476 striking out, in line 36, the word “physician” and inserting in place thereof the following word:-
2477 provider.

2478 SECTION 36. Said chapter 32A is hereby amended by adding the following section:-

2479 Section 27. The commission shall require any carriers or third party administrators with whom it
2480 contracts to provide a toll-free telephone number and website that enables consumers to request
2481 and obtain from the carrier or third party administrator, within 2 working days, the estimated or
2482 maximum allowed amount or charge for a proposed admission, procedure or service and the
2483 estimated amount the insured will be responsible to pay for a proposed admission, procedure or
2484 service that is a medically necessary covered benefit, based on the information available to the
2485 carrier or third party administrator at the time the request is made, including any facility fee,
2486 copayment, deductible, coinsurance or other out of pocket amount for any covered health care
2487 benefits; provided, that the insured shall not be required to pay more than the disclosed amounts
2488 for the covered health care benefits that were actually provided; provided, however, that nothing
2489 in this section shall prevent carriers from imposing cost sharing requirements disclosed in the
2490 insured’s evidence of coverage for unforeseen services that arise out of the proposed admission,

procedure or service; and provided further, that the carrier shall alert the insured that these are estimated costs, and that the actual amount the insured will be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

SECTION 37. Section 27 of chapter 32A, as inserted by section 36, is hereby amended by striking out the words “within 2 working days” and inserting in place thereof the following words:- “in real time”.

SECTION 38. Chapter 40J of the General Laws is hereby amended by striking out sections 6D and 6E, as so appearing, and inserting in place thereof the following 2 sections:-

Section 6D. (a) There shall be established an institute for health care innovation, technology and competitiveness, to be known as the Massachusetts e-Health Institute. The executive director of the corporation shall appoint a qualified individual to serve as the director of the institute, who shall be an employee of the corporation, report to the executive director and manage the affairs of the institute. The institute shall advance the dissemination of health information technology across the commonwealth, including the deployment of interoperable electronic health records systems in all health care provider settings that are networked through a statewide health information exchange. The institute shall (1) conduct the regional extension center program for the coordination and implementation of electronic health records systems by providers; (2) fulfill its current and any future contract obligations with the Office of Medicaid to administer specific operational components of the MassHealth electronic health records incentive program; and (3) develop a plan to complete the implementation of electronic health records systems by all providers in the commonwealth.

2512 (b) The institute, in consultation with the health information technology council
2513 established under section 2 of chapter 118I of the General Laws, shall advance the dissemination
2514 of health information technology and support the state's efforts in meeting the health care cost
2515 growth benchmark established under section 9 of chapter 6D by: (1) facilitating the
2516 implementation and use of interoperable electronic health records systems by health care
2517 providers in order to improve health care delivery and coordination, reduce unwarranted
2518 treatment variation, eliminate wasteful paper-based processes, help facilitate chronic disease
2519 management initiatives and establish transparency; (2) supporting the council in the creation and
2520 maintenance of a statewide interoperable electronic health information exchange that allows
2521 individual health care providers in all health care settings to exchange patient health information
2522 with other providers;(3) identifying and promoting an accelerated dissemination in the
2523 commonwealth of emerging health care technologies that have been developed and employed
2524 and that are expected to improve health care quality and lower health care costs, but that have not
2525 been widely implemented in the commonwealth, including, but not limited to, evidence-based
2526 clinical decision support and image exchange tools for advanced diagnostic imaging services; (4)
2527 facilitating health care providers in achieving and maintaining compliance with the standards for
2528 meaningful use, beyond stage 1, established by regulation by the United States Department of
2529 Health and Human Services under the Health Information Technology for Economic and Clinical
2530 Health Act and referred to in this section as "meaningful use"; and (5) promoting to patients,
2531 providers and the general public, a broad understanding of the benefits of interoperable
2532 electronic health records systems for care delivery, care coordination, improved quality and
2533 ultimately greater cost efficiency in the health care delivery system.

(c) The institute director shall prepare and annually update a statewide electronic health records plan. Each plan shall contain a budget for the application of funds from the e-Health Institute Fund for use in implementing each plan. The institute director shall submit the plans and updates, and associated budgets, to the council for its review and comment. Each plan and the associated budget shall be subject to approval of the board following review by the council. Each plan shall be consistent with the statewide health information exchange plan developed by the health information technology council under section 4 of chapter 118I.

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

Each plan as updated shall: (1) allow seamless, secure electronic exchange of health information among health care providers, health plans and other authorized users; (2) provide consumers with secure, electronic access to their own health information; (3) meet all applicable federal and state privacy and security requirements, including requirements imposed by 45 C.F.R. §§ 160, 162 and 164; (4) meet standards for interoperability adopted by the institute; provided that the standards are consistent with the statewide health information exchange plan developed by the health information technology council under section 5 of chapter 118I ; (5)

2557 give patients the option of allowing only designated health care providers to disseminate their
2558 individually identifiable information; (6) provide public health reporting capability as required
2559 under state law; (7) support any activities funded by the Healthcare Payment Reform Fund; and
2560 (8) allow reporting of health information other than identifiable patient health information for
2561 purposes of such activities as the secretary of health and human services may consider necessary.

2562 (d) The corporation may contract with implementing organizations to: (1) facilitate a
2563 public-private partnership that includes representation from hospitals, physicians and other
2564 health care professionals, health insurers, employers and other health care purchasers, health data
2565 and service organizations and consumer organizations; (2) provide resources and support to
2566 recipients of grants awarded under subsection (f) to implement each program within the
2567 designated community pursuant to the implementation plan; (3) certify and disburse funds to
2568 subcontractors, when necessary; (4) provide technical assistance to facilitate successful practice
2569 redesign, adoption of electronic health records and utilization of care management strategies; (5)
2570 ensure that electronic health records systems are fully interoperable and secure and that sensitive
2571 patient information is kept confidential by exclusively utilizing electronic health records
2572 products that are certified by the Office of the National Coordinator under the federal Health
2573 Information Technology for Economic and Clinical Health Act; and (6) certify, with approval of
2574 the corporation, a group of subcontractors who shall provide the necessary hardware and
2575 software for system implementation. Before to the institute's issuing requests for proposals for
2576 contracts to be entered into under this section, the institute's director shall consult with the
2577 council with respect to the content of all such proposals. Nothing in this section shall be
2578 construed to provide the corporation or the institute any authority with respect to any contract

relating to the development and implementation of the statewide health information exchange by the executive office of health and human services under section 2 of chapter 118I.

(e) Funding for the institute's activities shall be through the e-Health Institute Fund, established in section 6E. The institute, in consultation with the health information technology council, shall develop mechanisms for funding health information technology, including a grant program to assist health care providers with costs associated with health information technologies, including electronic health records systems, and coordinated with other electronic health records projects seeking federal reimbursement. Providers eligible for receipt of amounts from the Fund shall be limited to (1) any individual or institutional provider of health care services that is not in a category of individual or institutional provider eligible to receive Medicare or Medicaid incentive payments under the federal Health Information Technology for Economic and Clinical Health Act, such payments being referred to in this subsection as "incentive payments," and that lack access, as reasonably determined by the director of the institute, to resources needed to implement interoperable electronic health records systems that satisfy standards established by the institute; and (2) physicians, hospitals and community health centers that are eligible for incentive payments but lack access, as reasonably determined by the director of the institute, to resources needed to support their meeting meaningful use standards as determined in accordance with the federal Health Information Technology for Economic and Clinical Health Act. In the case of hospitals eligible for funding from the Distressed Hospital Trust Fund, established under section 2GGGG of chapter 29 and administered by the health policy commission under section 2 of chapter 6D, the institute shall first determine if there is available funding within the Distressed Hospital Fund to support their meeting meaningful use standards as determined in accordance with the federal Health Information Technology for

2602 Economic and Clinical Health Act. Individual or institutional providers under clause (1) may
2603 include, but shall not be limited to, mental health facilities and community-based behavioral
2604 health, substance use disorder and mental health care providers, chronic care and rehabilitation
2605 hospitals, skilled nursing facilities, visiting nursing associations, home health providers,
2606 registered nurses, licensed practical nurses, physicians, physician assistants, chiropractors,
2607 dentists, occupational therapists, physical therapists, optometrists, pharmacists, podiatrists,
2608 psychologists and social workers. In making the determinations regarding available resources as
2609 described in clauses (1) and (2), the director of the institute shall consider:

2610 (A) the demonstrated need for investment, taking into account all resources
2611 available to the particular provider including the relationship or affiliation of the particular
2612 provider to a health care delivery system and the capacity of such system to provide financial
2613 support for the provider's meeting the standards established by the institute or meaningful use
2614 standards;

2615 (B) the anticipated return on investment, as measured by improved health care
2616 coordination, reduction in health care costs, reduction in unwarranted treatment variation and
2617 elimination of wasteful paper-based processes;

2618 (C) the amount of financial or in-kind support the particular provider will commit
2619 to supplementing or supporting any investment by the corporation;

2620 (D) whether there is a reasonable likelihood that the provider's use of such
2621 amounts will achieve the long term benefits expected from implementing an interoperable
2622 electronic health records system;

2623 (E) whether the investment will support innovative health care delivery and
2624 payment models as identified by the health policy commission;

2625 (F) whether the investment will support efforts to integrate mental health,
2626 behavioral and substance use disorder services with overall medical care;

2627 (G) the extent to which the investment will support efforts to meet the health care
2628 cost growth benchmark established by the health policy commission;

2629 (H) whether the provider serves a high proportion of public payer clients; and

2630 (I) any other factors that the director determines are appropriate.

2631 The institute shall consult with the office of Medicaid to maximize all opportunities to
2632 qualify any expenditures for federal financial participation. Applications for funding shall be in
2633 the form and manner determined by the institute director, and shall include the information and
2634 assurances required by the institute director. The institute director may consider, as a condition
2635 for awarding grants, the grantee's financial participation and any other factors it deems relevant.

2636 All grants shall be recommended by the institute director and subsequently approved by
2637 the executive director. The institute director shall work with implementation organizations to
2638 oversee the grant-making process as it relates to an implementing organization's responsibilities
2639 under its contract with the corporation. Each recipient of monies from this program shall: (i)
2640 capture and report certain quality improvement data, as determined by the institute in
2641 consultation with the department of public health and the center for health information and
2642 analysis; (ii) fully implement an electronic health record system, including all clinical features,
2643 with the maximum feasible level of interoperability, not later than the second year of the grant;

and (iii) make use of the system's full range of features. In the event that any recipient of grant monies from this program does not achieve installation of a fully functioning electronic health record system or does not achieve the appropriate level of interoperability within the 2 year grant period, such recipient shall be required to repay to the corporation all or some portion, as determined by the corporation, of the grant funds previously provided to such recipient under this section.

(I) The institute shall establish a pilot partnership with community colleges or vocational technology schools in the commonwealth to support health information technology curriculum development and workforce development. Funding for the program shall be from the Health Care WorkForce Transformation Trust Fund established under section 2FFFF of chapter 29.

(J) The institute shall encourage and promote the implementation by hospitals, clinics, and health care networks of evidence-based best practice clinical decision support tools for the ordering provider of advanced diagnostic imaging services by January 1, 2017. Advanced diagnostic imaging services shall include, but is not limited to, computerized tomography, magnetic resonance imaging, magnetic resonance angiography, positron emission tomography, nuclear medicine, and such other imaging services. The institute shall develop clinical decision support guidelines and protocols that may be incorporated into the provider order entry systems of hospitals and the electronic health records of providers, to the maximum extent possible for certified EHR technology. The use of such decision support tools shall meet the privacy and security standards promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-119).

2665 In addition, the institute shall advance the dissemination of innovative technologies,
2666 including, but not limited to, those technologies that would allow diagnostic imaging exams to be
2667 seamlessly processed and transferred electronically through means that may include, but shall
2668 not be limited to, cloud-based technologies.

2669 (K) The institute shall file an annual report, not later than January 30, with the joint
2670 committee on health care financing, the joint committee on economic development and emerging
2671 technologies and the house and senate committees on ways and means concerning the activities
2672 of the institute in general and, in particular, describing the progress to date in implementing
2673 interoperableprovider electronic health records systems and recommending such further
2674 legislative action as it considers appropriate.

2675 Section 6E. (a) There shall be established and set up on the books of the corporation a
2676 separate fund to be known as the e-Health Institute Fund, referred to in this section as the fund.
2677 There shall be credited to the fund revenue from appropriations or other monies authorized by
2678 the general court and specifically designated to be credited to the fund, including but not limited
2679 to any investment income earned on the fund's assets and all other sources. The corporation
2680 shall hold the fund in an account or accounts separate from other funds, including other funds
2681 established under this chapter. Amounts credited to the fund shall be available for reasonable
2682 expenditure by the corporation, without further appropriation, for any and all activities consistent
2683 with this section and supportive of the purposes specified in section 6D, including but not limited
2684 to, in the form of grants, contracts, loans and such other vehicles as the corporation may
2685 determine are appropriate. Amounts credited to the fund shall be expended or applied only with
2686 the approval of the executive director of the corporation upon consultation with the health
2687 information technology council established under section 2 of chapter 118I of the General Laws.

Amounts credited to the fund shall not be applied to the commonwealth's match for federal funds for which a state match is required unless the federal funds to be matched are allocated to the corporation for use to further the purposes set out in this section, as reasonably determined by the executive director of the corporation; provided, however, that there are no other sources of funds available to meet federal matching requirements in order to secure such federal funds, as reasonably determined by the executive director of the corporation. Revenues deposited in the fund that are unexpended at the end of the fiscal year shall not revert to the General Fund and shall be available for expenditure in the following fiscal year.

SECTION 39. Said chapter 40J is hereby further amended by inserting after section 6E the following section:-

Section 6E ½. (a) There shall be established and set up on the books of the corporation the Massachusetts Health Information Technology Revolving Loan Fund, hereinafter referred to as the fund, the proceeds of which shall be used to provide zero-interest loans to health care providers and community-based behavioral health organizations to implement health information technology. There shall be credited to the fund any appropriations or other monies authorized by the general court and specifically designated to be credited to the fund; proceeds of any bonds or notes of the commonwealth issued for the purpose; any federal grants or loans; any private gifts, grants or donations made available; and any income derived from the investment of amounts credited to the fund. The director of the institute shall pursue and maximize all opportunities to qualify for federal financial participation. The institute shall seek, to the greatest extent possible, private gifts, grants and donations to the fund. The fund shall be held in an account or accounts separate from other funds. The fund shall be administered by the institute without further appropriation. Amounts credited to the fund shall be available for reasonable expenditure by the

2711 corporation, for purposes as the corporation determines are necessary to support the
2712 dissemination and development of health information technology in the commonwealth,
2713 including, but not limited to, the loan program established in this section. Any funds remaining
2714 in the fund at the end of a fiscal year shall be carried forward into the following fiscal year and
2715 shall remain available for expenditure without further appropriation.

2716 (b) The institute shall make available zero interest loan funding from the Massachusetts
2717 Health Information Technology Revolving Loan Fund to health care providers to assist with the
2718 development and implementation of an interoperable health information technology system that
2719 meets all federal and state requirements. The institute shall make the loans available through
2720 banks approved to do business in the commonwealth by the division of banks. The institute shall
2721 enter into agreements with the lenders to make loans. The institute, in consultation with the state
2722 treasurer, shall develop a lender partnership program and lender agreement that requires, at a
2723 minimum, (1) that a bank must be adequately capitalized, consistent with the requirements of
2724 209 CMR 47.00 et seq. and as defined under the prompt corrective action provisions of the
2725 Federal Deposit Insurance Act, 12 U.S.C. section 1831(o), and the Federal Deposit Insurance
2726 Corporation's Capital Adequacy Regulations, 12 CFR section 325.103; (2) the institute shall
2727 specify lending standards, including without limitation, those for determining eligibility,
2728 including the eligibility standards set forth in this subsection, size and number of loans, and (3)
2729 that all loans made under the program must be zero interest loans; provided, however, that the
2730 program may provide for reasonable application and administrative fees to be paid to lending
2731 banks under the program. A reasonable amount of administrative costs may be expended
2732 annually from the fund for the administration of the program. Any application or other fees
2733 imposed and collected under this program shall be deposited in the Massachusetts Health

2734 Information Technology Revolving Loan Fund for the duration of the loan program. The institute
2735 may make adjustments necessary to loan applications to account for reimbursements received
2736 under any other state or federal programs. To be eligible for a loan under this section, a health
2737 care provider, at a minimum, shall provide the participating lending institution with the
2738 following information: (A) the amount of the loan requested and a description of the purpose or
2739 project for which the loan proceeds will be used; (B) a price quote from a vendor; (C) a
2740 description of the health care provider or entities and other groups participating in the project;
2741 (D) evidence of financial condition and ability to repay the loan; and (E) a description of how the
2742 loan funds will be used to bring the health care provider into compliance with federal and state
2743 requirements. Loans shall be repaid over a 5-year term according to a schedule to be established
2744 through institute regulations. The attorney general shall enforce collection of any loans in
2745 default.

2746 The institute shall promulgate regulations necessary for the operation of this program.

2747 SECTION 40. Sections 6F and 6G of said chapter 40J are hereby repealed.

2748 SECTION 41. Chapter 62 of the General Laws is hereby amended by inserting after
2749 section 6M the following section:-

2750 Section 6N. (a) The purpose of this section shall be to provide incentives for business to
2751 recognize the benefits of wellness programs. Wellness programs implemented by business have
2752 resulted in both savings to their premiums as well as overall savings to the cost of health care.
2753 The goal of this tax credit is to provide smaller businesses with an expanded opportunity to
2754 implement these programs.

2755 (b) There is hereby established a Massachusetts wellness program tax credit. The total of
2756 all tax credits available to a taxpayer pursuant to this section or section 38FF of chapter 63 shall
2757 not exceed \$10,000 in any 1 tax year. A business that implements a wellness program shall be
2758 allowed a credit, to be computed as hereinafter provided, against taxes owed to the
2759 commonwealth under chapter 62 or chapter 63 or other applicable law. For the purposes of this
2760 section, "businesses" shall include professions, sole proprietorships, trades, businesses, or
2761 partnerships.

2762 (c) The credit allowed under this chapter shall be equal to 25 per cent of the costs
2763 associated with implementing a program certified under section 206A of chapter 111, with a
2764 maximum credit of \$10,000 per business in any 1 fiscal year. The department of public health
2765 shall determine the criteria for eligibility for the credit, the criteria to be set forth in regulations
2766 promulgated under this section and section 206A of chapter 111. The regulations shall require
2767 proof of using a wellness program qualified under section 206A of chapter 111. The department
2768 shall issue a certification to the taxpayer after the taxpayer submits documentation as required by
2769 the department. Such certification shall be acceptable as proof that the expenditures related to
2770 the implementation of a wellness program for the purposes of the credit allowed under this
2771 section.

2772 (d) Wellness program tax credits allowed to a business under this section shall be allowed
2773 for the taxable year in which the program is implemented; provided, however, that a tax credit
2774 allowed under this section shall not reduce the tax owed below zero. A taxpayer allowed a credit
2775 under this section for a taxable year may carry over and apply against such taxpayer's tax
2776 liability in any of the succeeding 5 taxable years, the portion, as reduced from year to year, of
2777 those credits which exceed the tax for the taxable year.

2778 SECTION 41A. Section 6N of chapter 62 of the General Laws is hereby repealed.

2779 SECTION 43. Section 21 of said chapter 62C, as so appearing, is hereby amended by
2780 striking out, in lines 141 and 142, the words “division of health care finance and policy” and
2781 inserting in place thereof the following words:- executive office of health and human services.

2782 SECTION 44. Section 21 of said chapter 62C, as so appearing, is hereby further amended
2783 by striking out, in line 143, the word “118G” and inserting in place thereof the following word:-
2784 118E.

2785 SECTION 45. Section 21 of said chapter 62C, as so appearing, is hereby further amended
2786 by striking out, in line 145, the words “division of health care finance and policy” and inserting
2787 in place thereof the following words:- executive office of health and human services.

2788 SECTION 46. Said section 21 of said chapter 62C, as so appearing, is hereby further
2789 amended by striking out, in lines 148 and 149, the words “section 39 of chapter 118G” and
2790 inserting in place thereof the following words:- section 69 of chapter 118E.

2791 SECTION 47. Section 1 of chapter 62D of the General Laws, as appearing in the 2010
2792 Official Edition, is hereby amended by striking out, in lines 8 and 9, the words “the division of
2793 health care finance and policy in the exercise of its duty to administer the uncompensated care
2794 pool pursuant to chapter 118G” and inserting in place thereof the following words:- the executive
2795 office of health and human services in the exercise of its duty to administer the Health Safety Net
2796 Trust Fund under chapter 118E.

2797 SECTION 48. Said section 1 of said chapter 62D, is hereby amended by striking out in
2798 lines 30 to 35, inclusive, as so appearing, the words “division of health care finance and policy

2799 on behalf of the uncompensated care pool by a person or a guarantor of a person who received
2800 free care services paid for in whole or in part by the uncompensated care pool or on whose behalf
2801 the uncompensated care pool paid for emergency bad debt, pursuant to subsection (m) of section
2802 18 of chapter 118G” and inserting in place thereof the following words:- executive office of
2803 health and human services on behalf of the Health Safety Net Trust Fund by a person or a
2804 guarantor of a person who received free care services paid for in whole or in part by the Health
2805 Safety Net Trust Fund or on whose behalf said fund paid for emergency bad debt.

2806 SECTION 49. Said section 1 of said chapter 62D is hereby amended by striking out, in
2807 line 55, as so appearing, the words “section 39 of chapter 118G” and inserting in place thereof
2808 the following words:- section 69 of chapter 118E.

2809 SECTION 50. Section 8 of said chapter 62D, as so appearing in the 2010 Official
2810 Edition, is hereby amended by striking out the second paragraph.

2811 SECTION 51. Section 10 of said chapter 62D, as so appearing, is hereby amended by
2812 striking out, in lines 8 and 9, the words “the division of medical assistance, the corporation, the
2813 office of the state comptroller, and the division of health care finance and policy” and inserting
2814 in place thereof the following words:- the office of medicaid, the corporation, the office of the
2815 state comptroller and the executive office of health and human services.

2816 SECTION 52. Section 13 of said chapter 62D, as so appearing, is hereby amended by
2817 striking out, in lines 11 and 12, the words “section 39 of chapter 118G” and inserting in place
2818 thereof the following words:- section 69 of chapter 118E.

2819 SECTION 53. Section 3 of chapter 62E of the General Laws, as so appearing, is hereby
2820 amended by striking out, in lines 7 and 8, the words “division of health care finance and policy”

2821 and inserting in place thereof the following words:- executive office of health and human
2822 services.

2823 SECTION 54. Section 12 of said chapter 62E, as so appearing, is hereby amended by
2824 striking out, in lines 19 and 20, the words “division of health care finance and policy” and
2825 inserting in place thereof the following words:- executive office of health and human services.

2826 SECTION 55. Said section 12 of said chapter 62E, as so appearing, is hereby further
2827 amended by striking out, in lines 21 and 22, the words “sections 34 to 39, inclusive, of chapter
2828 118G and sections 6B, 6C and 18B of chapter 118G” and inserting in place thereof the following
2829 words:- sections 64 to 69, inclusive, of chapter 118E and sections 17 and 18 of chapter 176Q.

2830 SECTION 56. Chapter 63 of the General Laws is hereby amended by inserting after
2831 section 38EE the following section:-

2832 Section 38FF. (a) The purpose of this section shall be to provide incentives for business
2833 to recognize the benefits of wellness programs. Wellness programs implemented by business
2834 have resulted in both savings to their premiums as well as overall savings to the cost of health
2835 care. The goal of this tax credit is to provide smaller businesses with an expanded opportunity to
2836 implement these programs.

2837 (b) There is hereby established a Massachusetts wellness program tax credit. The total of
2838 all tax credits available to a taxpayer pursuant to this section or section 6N of chapter 62 shall not
2839 exceed \$10,000 in any 1 tax year. A business that implements a wellness program shall be
2840 allowed a credit, to be computed as hereinafter provided, against taxes owed to the
2841 commonwealth under chapter 62 or chapter 63 or other applicable law. For the purposes of this

2842 section, “businesses” shall include professions, sole proprietorships, trades, businesses or
2843 partnerships.

2844 (c) The credit allowed under this chapter shall be equal to 25 per cent of the costs
2845 associated with implementing the program, with a maximum credit of \$10,000 per business in
2846 any 1 fiscal year. The department of public health shall determine the criteria for eligibility for
2847 the credit, such criteria to be set forth in regulations promulgated under this section. The
2848 regulations shall require proof of using a wellness program qualified under section 206A of
2849 chapter 111. The department shall issue a certification to the taxpayer after the taxpayer submits
2850 documentation as required by the department. The certification shall be acceptable as proof that
2851 the expenditures related to the implementation of a wellness program for the purposes of the
2852 credit allowed under this section.

2853 (d) The credit allowed in this chapter for any taxable year shall not reduce the excise to
2854 less than the amount due under subsection (b) of section 39, section 67 or any other applicable
2855 section.

2856 (e) Wellness program tax credits allowed to a business under this section shall be allowed
2857 for the taxable year in which the program is implemented. A taxpayer allowed a credit under this
2858 section for a taxable year may carry over and apply against the taxpayer’s tax liability in any of
2859 the succeeding 5 taxable years, the portion, as reduced from year to year, of those credits which
2860 exceed the tax for the taxable year.

2861 SECTION 56A. Section 38FF of chapter 63 of the General Laws is hereby repealed.

2862 SECTION 57. Section 17A of chapter 66 of the General Laws, as appearing in the 2010
2863 Official Edition, is hereby amended by striking out, in line 11, the word “118G” and inserting in
2864 place thereof the following word:- 118E.

2865 SECTION 58. Section 3 of chapter 71B of the General Laws, as so appearing, is hereby
2866 amended by striking out, in line 177, the words “2A of chapter 118G” and inserting in place
2867 thereof the following words:- 13C of chapter 118E.

2868 SECTION 59. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby
2869 amended by inserting after the definition of “Nuclear reactor” the following definition:-

2870 “Primary care provider”, a health care professional qualified to provide general medical
2871 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
2872 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
2873 maintains continuity of care within the scope of practice.

2874 SECTION 60. Said chapter 111 is hereby amended by inserting after section 2F the
2875 following 2 sections:-

2876 Section 2G. (a) There shall be established and set upon the books of the commonwealth a
2877 separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without
2878 further appropriation, by the department of public health. The fund shall consist of revenues
2879 collected by the commonwealth including: (1) any revenue from appropriations or other monies
2880 authorized by the general court and specifically designated to be credited to the fund; (2) any
2881 fines and penalties allocated to the fund under the General Laws; (3) any funds from public and
2882 private sources such as gifts, grants and donations to further community-based prevention

2883 activities; (4) any interest earned on such revenues; and (5) any funds provided from other
2884 sources.

2885 The commissioner of public health, as trustee, shall administer the fund. The
2886 commissioner, in consultation with the Prevention and Wellness Advisory Board established
2887 under section 2H, shall make expenditures from the fund consistent with subsections (d) and (e);
2888 provided, that not more than 15 per cent of the amounts held in the fund in any 1 year shall be
2889 used by the department for the combined cost of program administration, technical assistance to
2890 grantees or program evaluation.

2891 (b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall
2892 not revert to the General Fund and shall be available for expenditure in the following fiscal year.

2893 (c) All expenditures from the Prevention and Wellness Trust Fund shall support the
2894 state's efforts to meet the health care cost growth benchmark established in section 9 of chapter
2895 6D and any activities funded by the Healthcare Payment Reform Fund and 1 or more of the
2896 following purposes: (1) reduce rates of the most prevalent and preventable health conditions,
2897 including substance abuse; (2) increase healthy behaviors; (3) increase the adoption of
2898 workplace-based wellness or health management programs that result in positive returns on
2899 investment for employees and employers; (4) address health disparities; or (5) develop a stronger
2900 evidence-base of effective prevention programming.

2901 (d) The commissioner shall annually award not less than 75 per cent of the Prevention
2902 and Wellness Trust Fund through a competitive grant process to municipalities, community-
2903 based organizations, health care providers, regional-planning agencies, and health plans that
2904 apply for the implementation, evaluation and dissemination of evidence-based community

preventive health activities. To be eligible to receive a grant under this subsection, a recipient shall be: (1) a municipality or group of municipalities working in collaboration; (2) a community-based organization working in collaboration with 1 or more municipalities; (3) a health care provider or a health plan working in collaboration with 1 or more municipalities and a community-based organization; or (4) a regional planning agency. Expenditures from the fund for such purposes shall supplement and not replace existing local, state, private or federal public health-related funding; or a community-based organization or group of community-based organizations working in collaboration.

(e) A grant proposal submitted under subsection (d) shall include, but not be limited to: (1) a plan that defines specific goals for the reduction in preventable health conditions and health care costs over a multi-year period; (2) the evidence-based programs the applicant shall use to meet the goals; (3) a budget necessary to implement the plan, including a detailed description of any funding or in-kind contributions the applicant or applicants will be providing in support of the proposal; (4) any other private funding or private sector participation the applicant anticipates in support of the proposal; (5) a commitment to include women, racial and ethnic minorities and low income individuals; and (6) the anticipated number of individuals that would be affected by implementation of the plan.

Priority may be given to proposals in a geographic region of the state with a higher than average prevalence of preventable health conditions, as determined by the commissioner of public health, in consultation with the Prevention and Wellness Advisory Board. If no proposals were offered in areas of the state with particular need, the department shall ask for a specific request for proposal for that specific region. If the commissioner determines that no suitable

2927 proposals have been received, such that the specific needs remain unmet, the department may
2928 work directly with municipalities or community-based organizations to develop grant proposals.

2929 The department of public health shall, in consultation with the Prevention and Wellness
2930 Advisory Board, develop guidelines for an annual review of the progress being made by each
2931 grantee. Each grantee shall participate in any evaluation or accountability process implemented
2932 or authorized by the department.

2933 (f) The commissioner of public health may annually expend not more than 10 per cent of
2934 the Prevention and Wellness Trust Fund to support the increased adoption of workplace-based
2935 wellness or health management programming. The department of public health shall expend
2936 such funds for activities including, but not limited to: (1) developing and distributing
2937 informational tool-kits for employers, including a model wellness guide developed by the
2938 department; (2) providing technical assistance to employers implementing wellness programs;
2939 (3) hosting informational forums for employers; (4) promoting awareness of wellness tax credits
2940 provided through the state and federal government, including the wellness subsidy provided by
2941 the commonwealth health connector authority; (5) public information campaigns that quantify
2942 the importance of healthy lifestyles, disease prevention, care management and health promotion
2943 programs; and (6) providing stipends or grants to employers for the implementation and
2944 administration of workplace wellness programs in an amount up to 50 per cent of the costs
2945 associated with implementing the plan, subject to a cap as established by the commissioner based
2946 on available funds; provided, however, that any grants offered in connection with a workplace
2947 wellness program eligible for a tax credit under section 6N of chapter 62 and section 38FF of
2948 chapter 63 shall not, in combination with such tax credit, exceed 50 per cent of the costs
2949 associated with implementing the plan.

2950 The department of public health shall develop guidelines to annually review progress
2951 toward increasing the adoption of workplace-based wellness or health management
2952 programming.

2953 (g) The department of public health shall, annually on or before January 31, report on
2954 expenditures from the Prevention and Wellness Trust Fund. The report shall include, but not be
2955 limited to: (1) the revenue credited to the fund; (2) the amount of fund expenditures attributable
2956 to the administrative costs of the department of public health; (3) an itemized list of the funds
2957 expended through the competitive grant process and a description of the grantee activities; (4)
2958 the results of the evaluation of the effectiveness of the activities funded through grants; and (5)
2959 an itemized list of expenditures used to support workplace-based wellness or health management
2960 programs. The report shall be provided to the chairpersons of the house and senate committees
2961 on ways and means and the joint committee on public health and shall be posted on the
2962 department of public health's website.

2963 (h) The department of public health shall, under the advice and guidance of the
2964 Prevention and Wellness Advisory Board, annually report on its strategy for administration and
2965 allocation of the fund, including relevant evaluation criteria. The report shall set forth the
2966 rationale for such strategy, including, but not limited to: (1) a list of the most prevalent
2967 preventable health conditions in the commonwealth, including health disparities experienced by
2968 populations based on race, ethnicity, gender, disability status, sexual orientation or socio-
2969 economic status; (2) a list of the most costly preventable health conditions in the commonwealth;
2970 (3) a list of evidence-based or promising community-based programs related to the conditions
2971 identified in clauses (1) and (2); and (4) a list of evidence-based workplace wellness programs or
2972 health management programs related to the conditions in clauses (1) and (2). The report shall

2973 recommend specific areas of focus for allocation of funds. If appropriate, the report shall
2974 reference goals and best practices established by the National Prevention and Public Health
2975 Promotion Council and the Centers for Disease Control and Prevention, including, but not
2976 limited to the national prevention strategy, the healthy people report and the community
2977 prevention guide.

2978 (i) The department of public health shall promulgate regulations necessary to carry out
2979 this section.

2980 Section 2H. There shall be a Prevention and Wellness Advisory Board to make
2981 recommendations to the commissioner concerning the administration and allocation of the
2982 Prevention and Wellness Trust Fund established in section 2G, establish evaluation criteria and
2983 perform any other functions specifically granted to it by law.

2984 The board shall consist of: the commissioner of public health or a designee, who shall
2985 serve as chairperson; the executive director of the institute of health care finance and policy
2986 established in chapter 12C or a designee; the secretary of health and human services or a
2987 designee; and 14 persons to be appointed by the governor, 1 of whom shall be a person with
2988 expertise in the field of public health economics; 1 of whom shall be a person with expertise in
2989 public health research; 1 of whom shall be a person with expertise in the field of health equity; 1
2990 of whom shall be a person from a local board of health for a city or town with a population
2991 greater than 50,000; 1 of whom shall be a person of a board of health for a city or town with a
2992 population of fewer than 50,000; 2 of whom shall be representatives of health insurance carriers;
2993 1 of whom shall be a person from a consumer health organization; 1 of whom shall be a person
2994 from a hospital association; 1 of whom shall be a person from a statewide public health

2995 organization; 1 of whom shall be a representative of the interest of businesses; 1 of whom shall
2996 administer an employee assistance program; 1 of whom shall be a public health nurse or a school
2997 nurse; and 1 of whom shall be a person from an association representing community health
2998 workers.

2999 SECTION 61. Section 4H of chapter 111 of the General Laws, as appearing in the 2010
3000 Official Edition, is hereby amended by striking out, in line 20, the words “division of health care
3001 finance and policy” and inserting in place thereof the following words:- executive office of
3002 health and human services, or a governmental unit designated by the executive office.

3003 SECTION 62. Section 25B of said chapter 111, as so appearing, is hereby amended by
3004 striking out, in lines 23 and 24, the words “1 of chapter 118G” and inserting in place thereof the
3005 following words:- 8A of chapter 118E.

3006 SECTION 63. Said section 25B of said chapter 111, as so appearing, is hereby further
3007 amended by inserting after the word “has”, in line 35, the following word:- been.

3008 SECTION 64. Said section 25B of said chapter 111, as so appearing, is hereby further
3009 amended by striking out, in lines 47 and 48, the words “, institution for the care of unwed
3010 mothers”.

3011 SECTION 65. Said section 25B of said chapter 111, as so appearing, is hereby further
3012 amended by striking out, in line 49, the words “, which is an infirmary maintained in a town”.

3013 SECTION 66. Said section 25B of said chapter 111, as so appearing, is hereby further
3014 amended by striking out, in line 54, the words “mentally ill or retarded” and inserting in place
3015 thereof the following words:- developmentally disabled or mentally ill.

3016 SECTION 67. Said section 25B of said chapter 111, as so appearing, is hereby further
3017 amended by inserting after the word “basis”, in line 85, the following words:- whether provided
3018 in a free standing ambulatory surgical center licensed as a clinic pursuant to section 51 or by a
3019 hospital.

3020 SECTION 68. Said section 25B of said chapter 111, as so appearing, is hereby further
3021 amended by striking out the definition “Innovative service” and inserting in place thereof the
3022 following definition:-

3023 “Innovative service”, a service or procedure, which for reasons of quality, access, or cost
3024 is determined to be innovative by the department.

3025 SECTION 69. Said section 25B of said chapter 111, as so appearing, is hereby further
3026 amended by striking out the definition “New technology” and inserting in place thereof the
3027 following definition:-

3028 “New technology”, equipment such as magnetic resonance imagers and linear
3029 accelerators, as defined by the department, or a service, as defined by the department, which for
3030 reasons of quality, access or cost is determined to be new technology by the department.

3031 SECTION 70. Said section 25B of said chapter 111, as so appearing, is hereby further
3032 amended by striking out, in lines 120 to 121, the words “A new technology or innovate” and
3033 inserting in place thereof the following words:- a new technology or innovative.

3034 SECTION 71. Said chapter 111 is hereby amended by striking out section 25C and
3035 inserting in place thereof the following section:-

Section 25C. (a) Notwithstanding any general or special law to the contrary, except as provided in section 25 C½, a person or agency of the commonwealth or any political subdivision thereof shall not make substantial capital expenditures for construction of a health care facility or substantially change the service of the facility unless there is a determination by the department that there is need for the construction or change. A determination of need shall not be required for any substantial capital expenditure for construction or any substantial change in service which shall be related solely to the conduct of research in the basic biomedical or applied medical research areas and shall at no time result in any increase in the clinical bed capacity or outpatient load capacity of a health care facility and shall not be included within or cause an increase in the gross patient service revenue of a facility for health care services, supplies and accommodations, as such revenue shall be defined under section 31 of chapter 6A. Any person undertaking an expenditure related solely to that research which shall exceed or may reasonably be regarded as likely to exceed \$150,000 or any change in service solely related to the research, shall give written notice of the expenditure or change in service to the department the center for health information and analysis and the health policy commission, and the health policy commission at least 60 days before undertaking the expenditure or change in service. The notice shall state that the expenditure or change shall be related solely to the conduct of research in the basic biomedical or applied medical research areas and shall not be included within or result in any increase in the clinical bed capacity or outpatient load capacity of a facility and shall not cause an increase in the gross patient service revenue, as defined in under said section 31 of said chapter 6A, of a facility for health care services, supplies and accommodations; provided, however, that if it is subsequently determined that there was a violation of this section, the

3058 applicant may be punished by a fine of not more than 3 times the amount of the expenditure or
3059 value of the change of service.

3060 (b) Notwithstanding subsection (a), a determination of need shall be required for any such
3061 expenditure or change if the notice required by this section is not filed in accordance with the
3062 requirements of this section or if the department finds, after receipt of the notice, that the
3063 expenditure or change will not be related solely to research in the basic biomedical or applied
3064 medical research areas, will result in an increase in the clinical bed capacity or outpatient load
3065 capacity of a facility or will be included within or cause an increase in the gross patient service
3066 revenues of a facility. A research exemption granted under this section shall not be deemed to be
3067 evidence of need in any determination of need proceeding.

3068 (c) A person or agency of the commonwealth or any political subdivision thereof shall
3069 not provide an innovative service or use a new technology in any location other than in a health
3070 care facility, unless the person or agency first is issued a determination of need for the innovative
3071 service or new technology by the department.

3072 (d) A person or agency of the commonwealth or any political subdivision thereof shall
3073 not acquire for location in other than a health care facility a unit of medical, diagnostic, or
3074 therapeutic equipment, other than equipment used to provide an innovative service or which is a
3075 new technology, as such terms are defined in section 25B, with a fair market value in excess of
3076 \$250,000, to be adjusted in a similar fashion as section 25B1/2, unless the person or agency
3077 notifies the department of the person's or agency's intent to acquire the equipment and of the use
3078 that will be made of the equipment; provided, however, that maintenance or replacement of
3079 existing equipment defined as new technology shall not require a review. The notice shall be

made in writing and shall be received by the department at least 30 days before contractual arrangements are entered into to acquire the equipment with respect to which notice is given. A determination by the department of need shall be required for any the acquisition (1) if the notice required by this paragraph is not filed in accordance with the requirements of this paragraph, and (2) if the requirements for exemption under subsection (a) of section 25C½ are not met; provided, however, that in no event shall any person who acquires a unit of new technology for location other than in a health care facility refer or influence any referrals of patients to the equipment, unless the person is a physician directly providing services with that equipment; provided, however, that for the purposes of this section, a public advertisement shall not be deemed a referral or an influence of referrals; and provided, further, that any person who has an ownership interest in the equipment, whether direct or indirect, shall disclose the interest to patients utilizing said equipment in a conspicuous manner.

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

(f) Except as provided in section 25 C½, a person or agency of the commonwealth or any political subdivision thereof shall not acquire an existing health care facility unless the person or agency notifies the department of the person's or agency's intent to acquire the facility and of the services to be offered in the facility and its bed capacity. The notice shall be made in writing and shall be received by the department at least 30 days before contractual arrangements are entered into to acquire the facility with respect to which the notice is given. A determination of need shall be required for any such acquisition if the notice required by this subsection is not filed in accordance with the requirements of this subsection or if the department finds, within 30

3103 days after receipt of notice under this subsection, that the services or bed capacity of the facility
3104 will be changed in being acquired.

3105 (g) The department, in making any determination of need, shall be guided by the state
3106 health plan, shall encourage appropriate allocation of private and public health care resources
3107 and the development of alternative or substitute methods of delivering health care services so
3108 that adequate health care services will be made reasonably available to every person within the
3109 commonwealth at the lowest reasonable aggregate cost, shall take into account any comments
3110 from the center for health information and analysis, the health policy commission, and any other
3111 state agency or entity, and may impose reasonable terms and conditions as the department
3112 determines are necessary to achieve the purposes and intent of this section. The department may
3113 also recognize the special needs and circumstances of projects that: (1) are essential to the
3114 conduct of research in basic biomedical or health care delivery areas or to the training of health
3115 care personnel; (2) are unlikely to result in any increase in the clinical bed capacity or outpatient
3116 load capacity of the facility; and (3) are unlikely to cause an increase in the total patient care
3117 charges of the facility to the public for health care services, supplies, and accommodations, as
3118 such charges shall be defined from time to time in accordance with section 5 of chapter 409 of
3119 the acts of 1976.

3120 (h) Applications for such determination shall be filed with the department, together with
3121 other forms and information as shall be prescribed by, or acceptable to, the department. A
3122 duplicate copy of any application together with supporting documentation for such application,
3123 shall be a public record and kept on file in the department. The department may require a public
3124 hearing on any application at its discretion or at the request of the attorney general. The attorney
3125 general may intervene in any hearing under this section. A reasonable fee, established by the

3126 department, shall be paid upon the filing of such application; provided, however, that in no event
3127 shall such fee exceed 0.2 per cent of the capital expenditures, if any, proposed by the applicant.
3128 The department may also require the applicant to provide an independent cost-analysis,
3129 conducted at the expense of the applicant, to demonstrate that the application is consistent with
3130 the commonwealth's efforts to meet the health care cost-containment goals established by the
3131 commission.

3132 (i) Except in the case of an emergency situation determined by the department as
3133 requiring immediate action to prevent further damage to the public health or to a health care
3134 facility, the department shall not act upon an application for such determination unless: (1) the
3135 application has been on file with the department for at least 30 days; (2) the center for health care
3136 information and analysis, the health policy commission, the state and appropriate regional
3137 comprehensive health planning agencies and, in the case of long-term care facilities only, the
3138 department of elder affairs, or in the case of any facility providing inpatient services for the
3139 mentally ill or developmentally disabled, the departments of mental health or developmental
3140 services, respectively, have been provided copies of such application and supporting documents
3141 and given reasonable opportunity to comment on such application; and (3) a public hearing has
3142 been held on such application when requested by the applicant, the state or appropriate regional
3143 comprehensive health planning agency or any 10 taxpayers of the commonwealth. If, in any
3144 filing period, an individual application is filed which would implicitly decide any other
3145 application filed during such period, the department shall not act only upon an individual.

3146 (j) The department shall so approve or disapprove in whole or in part each such
3147 application for a determination of need within 4 months after filing with the department;
3148 provided, however, that the department may, on 1 occasion only, delay the action for up to 2

3149 months after the applicant has provided information which the department reasonably has
3150 requested during the 8 month period. Applications remanded to the department by the health
3151 facilities appeals board under section 25E shall be acted upon by the department within the same
3152 time limits provided in this section for the department to approve or disapprove applications for a
3153 determination of need. If an application has not been acted upon by the department within such
3154 time limits, the applicant may, within a reasonable period of time, bring an action in the nature of
3155 mandamus in the superior court to require the department to act upon the application.

3156 (k) Determinations of need shall be based on the written record compiled by the
3157 department during its review of the application and on such criteria consistent with sections 25B
3158 to 25G, inclusive, as were in effect on the date of filing of the application. In compiling such
3159 record the department shall confine its requests for information from the applicant to matters
3160 which shall be within the normal capacity of the applicant to provide. In each case the action by
3161 the department on the application shall be in writing and shall set forth the reasons for such
3162 action; and every such action and the reasons for such action shall constitute a public record and
3163 be filed in the department.

3164 (l) The department shall stipulate the period during which a determination of need shall
3165 remain in effect, which in no event shall originally be longer than 3 years but which may be
3166 extended by the department for cause shown. Any such determination shall continue to be
3167 effective only upon the applicant: (1) making reasonable progress toward completing the
3168 construction or substantial change in services for which need was determined to exist; (2)
3169 complying with all other laws relating to the construction, licensure and operation of health care
3170 facilities; and (3) complying with such further terms and conditions as the department reasonably
3171 shall require.

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

(n) A long-term care facility located in an under-bedded urban area shall not be replaced or the license for said facility transferred outside an under-bedded urban area. For the purposes of this subsection, an under-bedded urban area shall mean a city or town in which: (1) the per capita income is below the state average; (2) the percentage of the population below 100 per cent of the federal poverty level is above the state average; or (3) the percentage of the population below 200 per cent of the federal poverty level is above the state average.

SECTION 72. Said chapter 111 is hereby further amended by striking out sections 25L, 25M, and 25N and inserting in place thereof the following sections:-

Section 25L. (a) There shall be in the department a health care workforce center to improve access to health and behavioral, substance use disorder and mental health care services. The center, in consultation with the health care workforce advisory council established by section 25M and the secretary of labor and workforce development, shall: (1) coordinate the department's health care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention, including with the activities of the Health Care Workforce Transformation Fund; (2) monitor trends in access to primary care providers, and nurse practitioners and physician assistants practicing as primary care providers, behavioral, substance use disorder and mental health providers, and other

3194 physician and nursing providers, through activities including (i) reviewing existing data and
3195 collection of new data as needed to assess the capacity of the health care and behavioral,
3196 substance use disorder and mental health care workforce to serve patients, including patients
3197 with disabilities whose disabilities may include but are not limited to intellectual and
3198 developmental disabilities, including patient access and regional disparities in access to
3199 physicians, nurses, physician assistants, and behavioral, substance use disorder and mental health
3200 care professionals and to examine physician, nursing and physician assistant, behavioral,
3201 substance use disorder and mental health professionals' satisfaction; (ii) reviewing existing laws,
3202 regulations, policies, contracting or reimbursement practices, and other factors that influence
3203 recruitment and retention of physicians, nurses, physician assistants, behavioral, substance use
3204 disorder and mental health professionals; (iii) projecting the ability of the workforce to meet the
3205 needs of patients over time; (iv) identifying strategies currently being employed to address
3206 workforce needs, shortages, recruitment and retention; (v) studying the capacity of public and
3207 private medical, nursing, physician assistant, behavioral, substance use disorder and mental
3208 health professional schools in the commonwealth to expand the supply of primary care
3209 physicians and nurse practitioners and physician assistants practicing as primary care providers
3210 and licensed behavioral, substance use disorder and mental health professionals; (3) establish
3211 criteria to identify underserved areas in the commonwealth for administering the loan repayment
3212 program established under section 25N and for determining statewide target areas for health care
3213 provider placement based on the level of access; and (4) address health care workforce shortages
3214 through the following activities, including: (i) coordinating state and federal loan repayment and
3215 incentive programs for health care providers; (ii) providing assistance and support to
3216 communities, physician groups, community health centers and community hospitals in

3217 developing cost-effective and comprehensive recruitment initiatives; (iii) maximizing all sources
3218 of public and private funds for recruitment initiatives; (iv) designing pilot programs and making
3219 regulatory and legislative proposals to address workforce needs, shortages, recruitment and
3220 retention; and (v) making short-term and long-term programmatic and policy recommendations
3221 to improve workforce performance, address identified workforce shortages and recruit and retain
3222 physicians, nurses, physician assistants and behavioral, substance use disorder and mental health
3223 professionals.

3224 (b) The center shall maintain ongoing communication and coordination with the health
3225 disparities council, established by section 16O of chapter 6A.

3226 (c) The center shall annually submit a report, not later than March 1, to the governor, the
3227 health disparities council, established by section 16O of chapter 6A; and the general court, by
3228 filing the same with the clerk of the house of representatives, the clerk of the senate, the joint
3229 committee on labor and workforce development, the joint committee on health care financing,
3230 and the joint committee on public health. The report shall include: (1) data on patient access and
3231 regional disparities in access to physicians, by specialty and sub-specialty, and nurses, physician
3232 assistants, behavioral, substance use disorder and mental health professionals; (2) data on factors
3233 influencing recruitment and retention of physicians, nurses, physician assistants, and behavioral,
3234 substance use disorder and mental health professionals; (3) short and long-term projections of
3235 physician, nurse, physician assistant and behavioral, substance use disorder and mental health
3236 professionals supply and demand; (4) strategies being employed by the council or other entities
3237 to address workforce needs, shortages, recruitment and retention; (5) recommendations for
3238 designing, implementing and improving programs or policies to address workforce needs,

3239 shortages, recruitment and retention; and (6) proposals for statutory or regulatory changes to
3240 address workforce needs, shortages, recruitment and retention.

3241 Section 25M. (a) There shall be a healthcare workforce advisory council within, but not
3242 subject to the control of, the health care provider workforce center established by section 25L.
3243 The council shall advise the center on the capacity of the healthcare workforce to provide timely,
3244 effective, culturally competent, quality physician, nursing, physician assistant, behavioral,
3245 substance use disorder and mental health services.

3246 (b) The council shall consist of: 19 members to be appointed by the governor: 1 of whom
3247 shall be a representative of the Massachusetts Extended Care Federation; 1 of whom shall be a
3248 physician with a primary care specialty designation who practices in a rural area; 1 of whom
3249 shall be a physician with a primary care specialty who practices in an urban area; 1 of whom
3250 shall be a physician with a medical subspecialty; 1 of whom shall be an advanced practice nurse,
3251 authorized under section 80B of said chapter 112, who practices in a rural area; 1 of whom shall
3252 be an advanced practice nurse, authorized under said section 80B of said chapter 112, who
3253 practices in an urban area; 1 of whom shall be a representative of the Massachusetts
3254 Organization of Nurse Executives; 1 of whom shall be a representative of the Massachusetts
3255 Academy of Family Physicians; 1 of whom shall be a representative of the Massachusetts
3256 Workforce Board Association; 1 of whom shall be a representative of the Massachusetts League
3257 of Community Health Centers, Inc.; 1 of whom shall be a representative of the Massachusetts
3258 Medical Society; 1 of whom shall be a representative of the Massachusetts Center for Nursing,
3259 Inc.; 1 of whom shall be a representative of the Massachusetts Nurses Association; 1 of whom
3260 shall be a representative of the Massachusetts Association of Registered Nurses; 1 of whom shall
3261 be a representative of the Massachusetts Hospital Association, Inc.; 1 of whom shall be a

3262 representative from the Massachusetts Association of Physician Assistants; 1 of whom shall be a
3263 representative of the Massachusetts Chiropractic Society; 1 of whom shall be a representative of
3264 Health Care For All, Inc.; and 1 of whom shall be a behavioral, substance use disorder and
3265 mental health professional. Members of the council shall be appointed for terms of 3 years or
3266 until a successor is appointed. Members shall be eligible to be reappointed and shall serve
3267 without compensation, but may be reimbursed for actual and necessary expenses reasonably
3268 incurred in the performance of their duties. Vacancies of unexpired terms shall be filled within
3269 60 days by the appropriate appointing authority.

3270 The council shall meet at least bimonthly, at other times as determined by its rules and
3271 when requested by any 8 members.

3272 (c) The council shall advise the center on: (1) trends in access to primary care and
3273 physician subspecialties, nursing, physician assistant and behavioral, substance use disorder and
3274 mental health services; (2) the development and administration of the loan repayment program,
3275 established under section 25N, including criteria to identify underserved areas in the
3276 commonwealth; and (3) solutions to address identified health care workforces shortages; and (iv)
3277 the center's annual report to the general court.

3278 Section 25N. (a) There shall be a health care workforce loan repayment program,
3279 administered by the health care workforce center established by section 25L. The program shall
3280 provide repayment assistance for graduate and medical school loans to participants who: (1) are
3281 graduates of medical, nursing, or physician assistant schools or accredited graduate schools; (2)
3282 specialize in family health or medicine, internal medicine, pediatrics, obstetrics/gynecology,
3283 psychiatry, behavioral health, mental health or substance use disorder treatment; (3) demonstrate

3284 competency in health information technology, at least equivalent to federal meaningful use
3285 standards as set forth in 45 C.F.R. Part 170, including use of electronic medical records,
3286 computerized physician order entry and e-prescribing; and (4) meet other eligibility criteria,
3287 including service requirements, established by the board.

3288 Each recipient shall be required to enter into a contract with the commonwealth which
3289 shall obligate the recipient to perform a term of service of not less than 2 years in medically
3290 underserved areas as determined by the center.

3291 (b) The center shall promulgate regulations for the administration and enforcement of this
3292 section which shall include penalties and repayment procedures if a participant fails to comply
3293 with the service contract.

3294 The center shall, in consultation with the health care workforce advisory council and the
3295 public health council, establish criteria to identify medically underserved areas within the
3296 commonwealth. These criteria shall consist of quantifiable measures, which may include the
3297 availability of primary care medical services or behavioral, substance use disorder and mental
3298 health services within reasonable traveling distance, poverty levels and disparities in health care
3299 access or health outcomes.

3300 (c) The center shall evaluate the program annually, including exit interviews of
3301 participants to determine their post-program service plans and to solicit program improvement
3302 recommendations.

3303 (d) The center shall file an annual report, not later than July 1, with the governor, the
3304 clerks of the house of representatives and the senate, the house and senate committees on ways
3305 and means, the joint committee on health care financing, the joint committee on mental health

3306 and substance abuse and the joint committee on public health. The report shall include annual
3307 data and historical trends of: (1) the number of applicants, the number accepted and the number
3308 of participants by race, gender, medical, nursing, physician assistant, behavioral health,
3309 substance use, and mental health specialty, graduate, physician assistant, medical or nursing
3310 school, residence prior to graduate, medical, nursing, or physician assistant school and where
3311 they plan to practice after program completion; (2) the service placement locations and length of
3312 service commitments by participants; (3) the number of participants who fail to fulfill the
3313 program requirements and the reason for the failures; (4) the number of former participants who
3314 continue to serve in underserved areas; and (5) program expenditures.

3315 Section 25N 1/2 . (a) As used in this section, “primary care provider”, shall mean a
3316 health care professional qualified to provide general medical care for common health care
3317 problems who: (1) supervises, coordinates, prescribes or otherwise provides or proposes health
3318 care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within
3319 the scope of practice.

3320 (b) Pursuant to regulations to be promulgated by the health care workforce center, there
3321 shall be established a primary care residency grant program for the purpose of financing the
3322 training of primary care providers at teaching community health centers. Eligible applicants shall
3323 include teaching community health centers accredited through affiliations with a commonwealth-
3324 funded medical school or licensed as part of a teaching hospital with a residency program in
3325 primary care or family medicine and teaching health centers that are the independently
3326 accredited sponsoring organization for the residency program and whose residents are employed
3327 by the health center. Eligible residency programs shall be accredited by the Accreditation
3328 Council for Graduate Medical Education.

3329 To receive funding, an applicant shall: (1) include a review of recent graduates of the
3330 community health center's residency program, including information regarding what type of
3331 practice said graduates are involved in 2 years following graduation from the residency program;
3332 and (2) achieve a threshold of at least 50 per cent for the percentage of graduates practicing
3333 primary care within 2 years after graduation. Graduates practicing more than 50 per cent
3334 inpatient care or more than 50 per cent specialty care as listed in the American Medical
3335 Association Masterfile shall not qualify as graduates practicing primary care.

3336 Awardees of the primary care residency grant program shall maintain their teaching
3337 accreditation as either an independent teaching community health center or as a teaching
3338 community health center accredited through affiliation with a commonwealth-funded medical
3339 school or licensed as part of a teaching hospital.

3340 The health care workforce center shall determine through regulation grant amounts per
3341 full-time resident. Funds for such grants shall come from the Health Care Workforce
3342 Transformation Fund established under section 2FFFF of chapter 29.

3343 Section 25N $\frac{3}{4}$. There shall be established a primary care workforce development and
3344 loan forgiveness grant program at community health centers, for the purpose of enhancing
3345 recruitment and retention of primary care physicians and other clinicians at community health
3346 centers throughout the commonwealth. The grant program shall be administered by the
3347 department of public health; provided, that the department may contract with an organization to
3348 administer the grant program. Funds may be matched by other public and private funds.

3349 SECTION 73. Section 25P of said chapter 111 is hereby repealed.

3350 SECTION 74. Section 51 of said chapter 111, as so appearing in the 2010 Official
3351 Edition, is hereby amended by striking out, in line 25 the words “division of health care policy
3352 and finance” and inserting in place thereof the following words:- executive office of health and
3353 human services.

3354 SECTION 75. Said section 51 of said chapter 111, as so appearing, is hereby further
3355 amended by striking out, in lines 36 and 46, the words “division of health care finance and
3356 policy”, each time they appear, and inserting in place thereof, in each instance, the following
3357 words:- center for health information and analysis.

3358 SECTION 76. Said section 51 of said chapter 111, as so appearing, is hereby further
3359 amended by striking out, in lines 27 and 28, the words “pursuant to section 18 of chapter 118G”.

3360 SECTION 77. Section 51G of said chapter 111, as so appearing, is hereby amended by
3361 inserting after the word “ services,” in line 38, the first time it appears, the following words:-
3362 conduct a public hearing on the closure of said essential services or of the hospital. The
3363 department shall.

3364 SECTION 78. Said section 51G of said chapter 111, as so appearing, is hereby further
3365 amended by striking out, in line 40, the word “area,” and inserting in place thereof the following
3366 words:- area and shall.

3367 SECTION 79. Section 51H of said chapter 111, as so appearing, is hereby amended by
3368 striking out subsection (c) and inserting in place thereof the following subsection:-

3369 (c) The department, through interagency service agreements, shall transmit data collected
3370 under this section to the Betsy Lehman center for patient safety and medical error reduction for

3371 publication on the center for health information and analysis consumer health information
3372 website and for reporting quality data to providers. Any facility failing to comply with this
3373 section may: (i) be fined up to \$1,000 per day per violation; (ii) have its license revoked or
3374 suspended by the department; or (iii) be fined up to \$1,000 per day per violation and have its
3375 license revoked or suspended by the department.

3376 SECTION 80. Said chapter 111 is hereby further amended by inserting after section
3377 51H the following 2 sections:—

3378 Section 51I. (a) As used in this section the following words shall, unless the context
3379 clearly requires otherwise, have the following meanings:

3380 “Adverse event”, injury to a patient resulting from a medical intervention and not from
3381 the underlying condition of the patient.

3382 “Checklist of care”, pre-determined steps to be followed by a team of healthcare
3383 providers before, during and after a given procedure to decrease the possibility of adverse effects
3384 and other patient harm by articulating standards of care.

3385 “Facility,” a hospital, an institution maintaining an Intensive Care Unit, an institution
3386 providing surgical services or clinic providing ambulatory surgery.

3387 (b) The department shall encourage the development and implementation of checklists of
3388 care that prevent adverse events and reduce healthcare-associated infection rates. The department
3389 shall develop model checklists of care, which may be implemented by facilities; provided,
3390 however, that facilities may develop and implement checklists independently.

3391 (c) Facilities shall report data and information relative to the use or non-use of checklists
3392 to the department and the Betsy Lehman center for patient safety and medical error reduction.
3393 The department may consider facilities that use similar programs to be in compliance. Reports
3394 shall be made in the manner and form established by the department. The department shall
3395 publicly report on individual hospitals' compliance rates.

3396 Section 51J. The department shall promulgate regulations regarding limited services
3397 clinics. The regulations shall promote the availability of limited services clinics as a point of
3398 access for health care services within the full scope of practice of a nurse practitioner.

3399 Nothing in this section shall be interpreted to allow a limited service clinic to serve as a
3400 patient's primary care provider. Further, nothing in this section shall be interpreted to allow a
3401 limited service clinic to refer patients to a non-primary care provider, unless the limited service
3402 clinic is a satellite of, or is otherwise affiliated with, a health care facility licensed under section
3403 51 or other licensed practitioners and the non-primary care provider practice in the facility or is a
3404 licensed practitioner.

3405 SECTION 81. Section 52 of said chapter 111, as appearing in the 2010 Official Edition,
3406 is hereby amended by inserting after the definition of "Institution for unwed mothers" the
3407 following 2 definitions:-

3408 "Limited services", diagnosis, treatment, management and monitoring of acute and
3409 chronic disease, wellness and preventative services of a nature that may be provided within the
3410 scope of practice of a nurse practitioner using available facilities and equipment, including
3411 shared toilet facilities for point-of-care testing.

3412 "Limited services clinic", a clinic that provides limited services as defined by section 51J.

3413 SECTION 82. Said chapter 111 is hereby further amended by inserting, after section 53G, the
3414 following section:-

3415 Section 53H. No hospital shall enter into a contract or agreement which creates or
3416 establishes a partnership, employment or any other professional relationship with a licensed
3417 physician that would prohibit or limit the ability of that physician to provide testimony in an
3418 administrative or judicial hearing, including cases of medical malpractice.

3419 SECTION 83. Section 62M of said chapter 111, as appearing in the 2010 Official
3420 Edition, is hereby amended by striking out, in line 13, the words “division of health care finance
3421 and policy” and inserting in place thereof the following words:- executive office of health and
3422 human services or a governmental unit designated by the executive office.

3423 SECTION 84. Section 67C of said chapter 111, as so appearing, is hereby amended by
3424 striking out, in line 8, the words “division of health care finance and policy” and inserting in
3425 place thereof the following words:- executive office of health and human services.

3426 SECTION 85. Section 67F of said chapter 111, as so appearing, is hereby amended by
3427 striking out, in lines 15 and 19, the word “physician” and inserting in place thereof, in each
3428 instance, the following word:- provider.

3429 SECTION 86. Section 69H of said chapter 111, as so appearing, is hereby amended by
3430 striking out, in lines 2 and 3, the words “division of health care finance and policy” and inserting
3431 in place thereof the following words:- executive office of health and human services or a
3432 governmental unit designated by the executive office.

3433 SECTION 87. Chapter 111 of the General Laws is hereby amended by inserting after
3434 section 70G the following section:—

3435 Section 70H. Notwithstanding chapter 93A, sections 70E, 72E and 73 and 940 CMR
3436 section 4.09, a facility or institution licensed by the department of public health under section 71
3437 may move a resident to different living quarters or to a different room within the facility or
3438 institution if, as documented in the resident’s clinical record and as certified by a physician, the
3439 resident’s clinical needs have changed such that the resident either: (i) requires specialized
3440 accommodations, care, services, technologies or staffing not customarily provided in connection
3441 with the resident’s living quarters or room; or (ii) ceases to require the specialized
3442 accommodations, care, services, technologies or staffing customarily provided in connection
3443 with the resident’s living quarters or room; provided, however, that nothing in this section shall
3444 obviate a resident's notice and hearing rights when movement to different living quarters
3445 involves a resident moving from a Medicare-certified unit to a non-Medicare-certified unit or
3446 involves a resident moving from a non-Medicare-certified unit to a Medicare-certified unit; and
3447 provided further, that the resident shall have the right to appeal to the facility’s or institution’s
3448 medical director a decision to move the resident to a different living quarter or to a different
3449 room within the facility or institution.

3450 SECTION 88. Section 72P of said chapter 111, as appearing in the 2010 Official Edition,
3451 is hereby amended by striking out, in lines 20 and 21, the words “division of health care finance
3452 and policy” and inserting in place thereof the following words:- center for health information and
3453 analysis.

3454 SECTION 89. Section 72Q of said chapter 111, as so appearing, is hereby amended by
3455 striking out, in lines 2 and 3, the words “division of health care finance and policy” and inserting
3456 in place thereof the following words:- center for health information and analysis.

3457 SECTION 90. Section 72Y of said chapter 111, as so appearing, is hereby amended by
3458 striking out, in lines 43 and 47, the words “7 of chapter 118G” and inserting in place thereof, in
3459 each instance, the following words:- 13D of chapter 118E.

3460 SECTION 91. Section 78 of said chapter 111, as so appearing, is hereby amended by
3461 striking out, in lines 19 and 20, the words “division of health care finance and policy” and
3462 inserting in place thereof the following words:- executive office of health and human services or
3463 a governmental unit designated by the executive office.

3464 SECTION 92. Section 78A of said chapter 111, as so appearing, is hereby amended by
3465 striking out, in line 14, the words “division of health care finance and policy” and inserting in
3466 place thereof the following words:- executive office of health and human services or a
3467 governmental unit designated by the executive office.

3468 SECTION 93. Section 79 of said chapter 111, as so appearing, is hereby amended by
3469 striking out, in line 9, the words “division of health care finance and policy” and inserting in
3470 place thereof the following words:- executive office of health and human services or a
3471 governmental unit designated by the executive office.

3472 SECTION 94. Section 80 of said chapter 111, as so appearing, is hereby amended by
3473 striking out, in lines 5 and 6, the words “division of health care finance and policy” and inserting
3474 in place thereof the following words:- executive office of health and human services or a
3475 governmental unit designated by the executive office.

3476 SECTION 95. Said section 80 of said chapter 111, as so appearing, is hereby further
3477 amended by striking out, in line 8, the word “division” and inserting in place thereof the
3478 following words:- executive office.

3479 SECTION 96. Section 82 of said chapter 111, as so appearing, is hereby amended by
3480 striking out, in lines 22 and 23, the words “division of health care finance and policy” and
3481 inserting in place thereof the following words:- executive office of health and human services or
3482 a governmental unit designated by the executive office.

3483 SECTION 97. Said section 82 of said chapter 111, as so appearing, is hereby further
3484 amended by striking out, in line 24, the word “division” and inserting in place thereof the
3485 following words:- executive office.

3486 SECTION 98. Section 88 of said chapter 111, as so appearing, is hereby amended by
3487 striking out, in line 16, the words “division of health care finance and policy” and inserting in
3488 place thereof the following words:- executive office of health and human services or a
3489 governmental unit designated by the executive office.

3490 SECTION 99. Section 116A of said chapter 111, as so appearing, is hereby amended by
3491 striking out, in line 2, the words “division of health care finance and policy” and inserting in
3492 place thereof the following words:- executive office of health and human services or a
3493 governmental unit designated by the executive office.

3494 SECTION 100. Said chapter 111 is hereby further amended by inserting after section
3495 206 the following section:-

3496 Section 206A. (a) The department, in consultation with the division of insurance, shall
3497 provide a seal of approval to wellness programs implemented by businesses. In developing
3498 criteria for a wellness seal of approval, the department shall consider: (i) actuarial equivalency to
3499 programs under section 206; (ii) whether the program provides new or innovative services; (iii)
3500 the participation rate by employees; (iv) the quality of the health education being provided; (v)
3501 whether the program promotes health screenings and other preventive health care measures; and
3502 (vi) whether the program promotes a healthy workplace environment. For the purposes of this
3503 section, "businesses" shall include professions, sole proprietorships, trades, businesses or
3504 partnerships

3505 (b) The commissioner, in consultation with the commissioner of the department of
3506 revenue, shall create a form that indicates a business is using an approved wellness program.

3507 SECTION 101. Subsection (a) of section 217 of said chapter 111, as appearing in the
3508 2010 Official Edition, is hereby amended by striking out clause (2) and inserting in place thereof
3509 the following clause:-

3510 (2) establish a site on the internet and through other communication media in order to
3511 make managed care information collected by the office readily accessible to consumers. Said
3512 internet site shall, at a minimum, include: (i) a chart, prepared by the office, comparing the
3513 information obtained on premium revenue expended for health care services under clause (3) of
3514 subsection (b) of section 7 of chapter 176O, for the most recent year for which information is
3515 available; and (ii) data collected under subsection (c).

3516 SECTION 102. Said section 217 of said chapter 111, as so appearing, is hereby further
3517 amended by striking out, in lines 48 and 49, the words "the division of health care finance and

3518 policy pursuant to section 24 of chapter 118G” and inserting in place thereof the following
3519 words:- the center for health information and analysis.

3520 SECTION 103. Said chapter 111 is hereby further amended by adding the following 4
3521 sections:—

3522 Section 225. (a) For the purposes of this section, the following words shall, unless the
3523 context clearly requires otherwise, have the following meanings:

3524 “Anatomic pathology service”, histopathology, surgical pathology, cytopathology,
3525 hematology, subcellular pathology, molecular pathology and blood-banking services performed
3526 by a pathologist.

3527 “Charge”, the uniform price for specific services within a revenue center of a hospital.

3528 “Cytopathology”, the examination of cells from the following:

3529 (i) fluids;

3530 (ii) aspirates;

3531 (iii) washings;

3532 (iv) brushings; or

3533 (v) smears, including the pap test examination performed by a physician or under
3534 the supervision of a physician.

3535 “Hematology”, the microscopic evaluation of bone marrow aspirates and biopsies
3536 performed by a physician or under the supervision of a physician, and peripheral blood smears

3537 when the attending or treating physician or technologist requests that a blood smear be reviewed
3538 by a pathologist.

3539 “Histopathology” or “surgical pathology”, the gross and microscopic examination of
3540 organ tissue performed by a physician or under the supervision of a physician.

3541 “Patient”, any natural person receiving health care services.

3542 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
3543 patient for a charge.

3544 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX of
3545 the federal Social Security Act programs, other governmental payers, insurance companies,
3546 health maintenance organizations and nonprofit hospital service corporations. Third party payer
3547 shall not include a purchaser responsible for payment for health care services rendered by a
3548 hospital, either to the purchaser or to the hospital.

3549 (b) A clinical laboratory or physician providing anatomic pathology services for patients
3550 in the commonwealth shall present or cause to be presented a claim, bill or demand for payment
3551 for these services only to the following:

3552 (i) the patient directly;

3553 (ii) the responsible insurer or other third-party payer;

3554 (iii) the hospital, public health clinic or nonprofit health clinic ordering such
3555 services;

3556 (iv) the referral laboratory or a physician's office laboratory when the physician
3557 of such laboratory performs the anatomic pathology service; or

3558 (v) the governmental agency or its specified public or private agent, agency or
3559 organization on behalf of the recipient of the services.

3560 (c) Except as provided under this section, no licensed practitioner shall, directly or
3561 indirectly, charge, bill or otherwise solicit payment for anatomic pathology services unless the
3562 services were rendered personally by the licensed practitioner or under the licensed practitioner's
3563 direct supervision under section 353 of the Public Health Service Act, 42 U.S.C. § 263a.

3564 (d) No patient, insurer, third party payer, hospital, public health clinic or non-profit health
3565 clinic shall be required to reimburse any licensed practitioner for charges or claims submitted in
3566 violation of this section.

3567 (e) Nothing in this section shall be construed to mandate the assignment of benefits for
3568 anatomic pathology services.

3569 (f) Nothing in this section shall prohibit billing between laboratories for anatomic
3570 pathology services in instances where a sample must be sent to another specialist. Nothing in this
3571 section shall authorize a physician's office laboratory to bill for anatomic pathology services
3572 when the physician of such laboratory has not performed the anatomic pathology service.

3573 (g) The board of registration in medicine may revoke, suspend or deny renewal of the
3574 license of a practitioner who violates this section.

3575 Section 226. For purposes of this section, "mandatory overtime" shall mean any hours
3576 worked by a nurse in a hospital setting to deliver patient care, beyond the predetermined and

3577 regularly scheduled number of hours that the hospital and nurse have agreed that the employee
3578 shall work, provided that in no case shall such predetermined and regularly scheduled number of
3579 hours exceed 12 hours in any 24 hour period.

3580 (b) Notwithstanding any general or special law to the contrary, a hospital shall not require
3581 a nurse to work mandatory overtime except in the case of an emergency situation where the
3582 safety of the patient requires its use and when there is no reasonable alternative.

3583 (c) Under subsection (b), whenever there is an emergency situation where the safety of a
3584 patient requires its use and when there is no reasonable alternative, the facility shall, before
3585 requiring mandatory overtime, make a good faith effort to have overtime covered on a voluntary
3586 basis. Mandatory overtime shall not be used as a practice for providing appropriate staffing for
3587 the level of patient care required.

3588 (d) Under subsection (c), the health policy commission established under section 2 of
3589 chapter 6D, shall develop guidelines and procedures to determine what constitutes an emergency
3590 situation for the purposes of allowing mandatory overtime. In developing those guidelines, the
3591 commission shall consult with those employees and employers who would be affected by such a
3592 policy. The Commission shall solicit comment from those same parties through a public hearing.

3593 (e) Hospitals shall report all instances of mandatory overtime and the circumstances
3594 requiring its use to the department of public health. Such reports shall be public documents.

3595 (f) A nurse shall not be allowed to exceed 16 consecutive hours worked in a 24 hour
3596 period. In the event a nurse works 16 consecutive hours, that nurse must be given at least 8
3597 consecutive hours of off-duty time immediately after the worked overtime.

3598 (g) This section is intended as a remedial measure to protect the public health and the
3599 quality and safety of patient care and shall not be construed to diminish or waive any rights of
3600 the nurse under other laws, regulations or collective bargaining agreements. The refusal of a
3601 nurse to accept work in excess of the limitations set forth in this section shall not be grounds for
3602 discrimination, dismissal, discharge or any other employment decision.

3603 (h) Nothing in this section shall be construed to limit, alter or modify the terms,
3604 conditions or provisions of a collective bargaining agreement entered into by a hospital and a
3605 labor organization.

3606 Section 227. (a) As used in this section the following terms shall, unless the context
3607 clearly requires otherwise, have the following meanings:

3608 “Appropriate”, consistent with applicable legal, health and professional standards, the
3609 patient’s clinical and other circumstances and the patient’s reasonably known wishes and beliefs.

3610 “Attending health care practitioner”, a physician or nurse practitioner who has primary
3611 responsibility for the care and treatment of the patient; provided that if more than 1 physician or
3612 nurse practitioner share that responsibility, each of them shall have a responsibility under this
3613 section, unless there is an agreement to assign that responsibility to 1 such person.

3614 “Palliative care”, a health care treatment, including interdisciplinary end-of-life care and
3615 consultation with patients and family members, to prevent or relieve pain and suffering and to
3616 enhance the patient’s quality of life, including hospice care.

3617 “Terminal illness or condition”, an illness or condition which can reasonably be expected
3618 to cause death within 6 months, whether or not treatment is provided.

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

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

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

Nothing in this section shall be construed to permit a healthcare professional to offer to provide information about assisted suicide or the prescribing of medication to end life.

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

3641 Section 228. (a) Prior to an admission, procedure or service and upon request by a
3642 patient or prospective patient, a health care provider shall, within 2 working days, disclose the
3643 allowed amount or charge of the admission, procedure or service, including the amount for any
3644 facility fees required; provided, however, that if a health care provider is unable to quote a
3645 specific amount in advance due to the health care provider's inability to predict the specific
3646 treatment or diagnostic code, the health care provider shall disclose the estimated maximum
3647 allowed amount or charge for a proposed admission, procedure or service, including the amount
3648 for any facility fees required.

3649 (b) If a patient or prospective patient is covered by a health plan, a health care provider
3650 who participates as a network provider shall, upon request of a patient or prospective patient,
3651 provide, based on the information available to the provider at the time of the request, sufficient
3652 information regarding the proposed admission, procedure or service for the patient or prospective
3653 patient to use the applicable toll-free telephone number and website of the health plan established
3654 to disclose out-of-pocket costs, under section 23 of chapter 176O. A health care provider may
3655 assist a patient or prospective patient in using the health plan's toll-free number and website.

3656 (b) A health care provider referring a patient to another provider that is part of or
3657 represented by the same provider organization as defined in section 11 of chapter 6D shall
3658 disclose that the providers are part of or represented by the same provider organization.

3659 As used in this section, "allowed amount", shall mean the contractually agreed upon
3660 amount paid by a carrier to a health care provider for health care services provided to an insured.

SECTION 104. Section 1 of chapter 111K of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words “established by section 18 of chapter 118G”.

SECTION 105. Section 10 of said chapter 111K, as so appearing, is hereby amended by striking out, in lines 2 and 3, the words “division of health care finance and policy”, and inserting in place thereof the following words:- center for health information and analysis.

SECTION 106. Section 3 of chapter 111M of the General Laws, as so appearing, is hereby amended by striking out, in line 10, the words “division of health care finance and policy” and inserting in place thereof the following words:- center for health information and analysis.

SECTION 107. Said section 3 of said chapter 111M, as so appearing, is hereby further amended by striking out, in line 11, the word “division” and inserting in place thereof the following word:- center.

SECTION 108. The first paragraph of section 2 of chapter 112 of the General Laws, as so appearing, is hereby amended by inserting after the second sentence the following 2 sentences:—
The board shall require, as a standard of eligibility for licensure, that applicants demonstrate proficiency in the use of computerized physician order entry, e-prescribing, electronic health records and other forms of health information technology, as determined by the board. As used in this section, proficiency, at a minimum shall mean that applicants demonstrate the skills to comply with the “meaningful use” requirements, as set forth in 45 C.F.R. Part 170.

SECTION 109. Said chapter 112 is hereby further amended by inserting, after section 2C, the following section:-

3683 Section 2D. No physician shall enter into a contract or agreement which creates or
3684 establishes a partnership, employment or any other form of professional relationship that
3685 prohibits a physician from providing testimony in an administrative or judicial hearing, including
3686 cases of medical malpractice.

3687 SECTION 110. Section 9C of said chapter 112, as appearing in the 2010 Official
3688 Edition, is hereby amended by striking out the definition of “Physician assistant” and inserting in
3689 place thereof the following definition:-

3690 “Physician assistant,” a person who is duly registered and licensed by the board.

3691 SECTION 111. The first paragraph of section 9E of said chapter 112 , as so appearing, is
3692 hereby amended by striking out the last sentence.

3693 SECTION 112. The third paragraph of said section 9E of said chapter 112, as so
3694 appearing, is hereby amended by striking out the last sentence.

3695 SECTION 113. Said chapter 112 is hereby further amended by inserting after section
3696 80H the following section:—

3697 Section 80I. When a law or rule requires a signature, certification, stamp, verification,
3698 affidavit or endorsement by a physician, when relating to physical or mental health, that
3699 requirement may be fulfilled by a nurse practitioner practicing under section 80B. Nothing in
3700 this section shall be construed to expand the scope of practice of nurse practitioners. This
3701 section shall not be construed to preclude the development of mutually agreed upon guidelines
3702 between the nurse practitioner and supervising physician under section 80E.

3703 SECTION 114. Section 8 of chapter 118E of the General Laws, as appearing in the 2010
3704 Official Edition, is hereby amended by inserting after clause e the following paragraph:-

3705 e1/2. “Primary care provider”, a health care professional qualified to provide general
3706 medical care for common health care problems who: (i) supervises, coordinates, prescribes or
3707 otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and
3708 (iii) maintains continuity of care within the scope of practice.

3709 SECTION 115. Said chapter 118E is hereby amended by inserting after section 8 the
3710 following section:—

3711 Section 8A. For the purposes of sections 13C to 13K, inclusive, and sections 64 to 70,
3712 inclusive, the following terms and phrases shall, unless the context clearly requires otherwise,
3713 have the following meanings:

3714 “Actual costs”, all direct and indirect costs incurred by a hospital or a community health
3715 center in providing medically necessary care and treatment to its patients, determined in
3716 accordance with generally accepted accounting principles.

3717 “Acute hospital”, the teaching hospital of the University of Massachusetts Medical
3718 School and any hospital licensed under section 51 of chapter 111 and which contains a majority
3719 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of
3720 public health.

3721 “Case mix”, the description and categorization of a hospital’s patient population
3722 according to criteria approved by the center for health information and analysis including, but

3723 not limited to, primary and secondary diagnoses, primary and secondary procedures, illness
3724 severity, patient age and source of payment.

3725 “Charge”, the uniform price for specific services within a revenue center of a hospital.

3726 “Child”, a person who is under 18 years of age.

3727 “Community health centers”, health centers operating in conformance with Section 330
3728 of United States Public Law 95-626 and shall include all community health centers which file
3729 cost reports as requested by the center.

3730 “Comprehensive cancer center”, the hospital of any institution so designated by the
3731 national cancer institute organized solely for the treatment of cancer, and offered exemption from
3732 the Medicare diagnosis related group payment system.

3733 “Disproportionate share hospital”, an acute hospital that exhibits a payer mix where a
3734 minimum of 63 per cent of the acute hospital’s gross patient service revenue is attributable to
3735 Title XVIII and Title XIX of the federal Social Security Act, other government payers and free
3736 care.

3737 “Emergency medical condition”, a medical condition, whether physical or mental,
3738 manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of
3739 prompt medical attention could reasonably be expected by a prudent layperson who possesses an
3740 average knowledge of health and medicine, to result in placing the health of the person or
3741 another person in serious jeopardy, serious impairment to body function or serious dysfunction
3742 of any body organ or part or, with respect to a pregnant woman, as further defined in 42 U.S.C.
3743 section 1395dd(e)(1)(B).

3744 “Emergency services”, medically necessary health care services provided to an individual
3745 with an emergency medical condition.

3746 “Employee”, a person who performs services primarily in the commonwealth for
3747 remuneration for a commonwealth employer; provided, that “employee” shall not include a
3748 person who is self-employed.

3749 “Employer”, an employer as defined in section 1 of chapter 151A.

3750 “Enrollee”, a person who becomes a member of an insurance program of the division
3751 either individually or as a member of a family.

3752 “Financial requirements”, a hospital’s requirement for revenue which shall include, but
3753 not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of
3754 depreciation of plant and equipment and the reasonable costs associated with changes in medical
3755 practice and technology.

3756 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
3757 ends in the calendar year by which it is identified.

3758 “Free care”, the following medically necessary services provided to individuals
3759 determined to be financially unable to pay for care, in whole or in part, under applicable
3760 regulations of the executive office: (i) services provided by acute hospitals; (ii) services provided
3761 by community health centers; and (iii) patients in situations of medical hardship in which major
3762 expenditures for health care have depleted or can reasonably be expected to deplete the financial
3763 resources of the individual to the extent that medical services cannot be paid, as determined by
3764 regulations of the executive office.

3765 “General health supplies, care or rehabilitative services and accommodations”, all
3766 supplies, care and services of medical, optometric, dental, surgical, podiatric, psychiatric,
3767 therapeutic, diagnostic, rehabilitative, supportive or geriatric nature, including inpatient and
3768 outpatient hospital care and services and accommodations in hospitals, sanatoria, infirmaries,
3769 convalescent and nursing homes, retirement homes, facilities established, licensed or approved
3770 under chapter 111B and providing services of a medical or health-related nature and similar
3771 institutions including those providing treatment, training, instruction and care of children and
3772 adults; provided, however, that rehabilitative service shall include only rehabilitative services of
3773 a medical or health-related nature which are eligible for reimbursement under Title XIX of the
3774 federal Social Security Act.

3775 “Governmental mandate”, a state or federal statutory requirement, administrative rule,
3776 regulation, assessment, executive order, judicial order or other governmental requirement that
3777 directly or indirectly imposes an obligation and associated compliance cost upon a provider to
3778 take an action or to refrain from taking an action in order to fulfill the provider’s contractual duty
3779 to a procuring governmental unit.

3780 “Governmental unit”, the commonwealth, any department, agency board, commission or
3781 political subdivision of the commonwealth.

3782 “Gross patient service revenue”, the total dollar amount of a hospital’s charges for
3783 services rendered in a fiscal year.

3784 “Health care services”, supplies, care and services of a medical, surgical, optometric,
3785 dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative,
3786 supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital

3787 care and services, services provided by a community health center or by a sanatorium, included
3788 in the definition of “hospital” in Title XVIII of the federal Social Security Act and treatment and
3789 care compatible with such services or by a health maintenance organization.

3790 “Health insurance company”, a company as defined in section 1 of chapter 175 which
3791 engages in the business of health insurance.

3792 “Health insurance plan”, the Medicare program or an individual or group contract or
3793 other plan providing coverage of health care services and which is issued by a health insurance
3794 company, a hospital service corporation, a medical service corporation or a health maintenance
3795 organization.

3796 “Health maintenance organization”, a company which provides or arranges for health
3797 care services to enrolled members in exchange primarily for a prepaid per capita or aggregate
3798 fixed sum as defined in section 1 of chapter 176G.

3799 “Hospital”, a hospital licensed under section 51 of chapter 111, the teaching hospital of
3800 the University of Massachusetts Medical School and any psychiatric facility licensed under
3801 section 19 of chapter 19.

3802 “Medical assistance program”, the Medicaid program, the Veterans Administration health
3803 and hospital programs and any other medical assistance program operated by a governmental
3804 unit for persons categorically eligible for such program.

3805 “Medically necessary services”, medically necessary inpatient and outpatient services as
3806 mandated under Title XIX of the federal Social Security Act. Medically necessary services shall
3807 not include: (i) non-medical services, such as social, educational and vocational services; (ii)

3808 cosmetic surgery; (iii) canceled or missed appointments; (iv) telephone conversations and
3809 consultations; (v) court testimony; (vi) research or the provision of experimental or unproven
3810 procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-
3811 surgery hormone therapy; and (vii) providing whole blood; provided, however, that
3812 administrative and processing costs associated with providing blood and its derivatives shall be
3813 payable.

3814 “Medicare program”, the medical insurance program established by Title XVIII of the
3815 federal Social Security Act.

3816 “Non-acute hospital”, a hospital which is not an acute hospital.

3817 “Patient”, a natural person receiving health care services from a hospital.

3818 “Pediatric hospital”, an acute care hospital which limits services primarily to children and
3819 which qualifies as exempt from the Medicare Prospective Payment system regulations.

3820 “Pediatric specialty unit”, a pediatric unit of an acute care hospital in which the ratio of
3821 licensed pediatric beds to total licensed hospital beds as of July 1, 1994, exceeded 0.20. In
3822 calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds
3823 and the total of all licensed hospital beds shall include the total of all licensed acute care hospital
3824 beds, consistent with Medicare’s acute care hospital reimbursement methodology as put forth in
3825 the Provider Reimbursement Manual Part 1, Section 2405.3G.

3826 “Provider”, any person, corporation partnership, governmental unit, state institution or
3827 any other entity qualified under the laws of the commonwealth to perform or provide health care
3828 services.

3829 “Publicly aided patient”, a person who receives hospital care and services for which a
3830 governmental unit is liable, in whole or in part, under a statutory program of public assistance.

3831 “Purchaser”, a natural person responsible for payment for health care services rendered
3832 by a hospital.

3833 “Resident”, a person living in the commonwealth, as defined by the executive office
3834 through a regulation; provided, however, that such regulation shall not define a resident as a
3835 person who moved into the commonwealth for the sole purpose of securing health insurance
3836 under this chapter; and provided, further that confinement of a person in a nursing home, hospital
3837 or other medical institution shall not in and of itself, suffice to qualify such person as a resident.

3838 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
3839 patient for a charge.

3840 “Self-employed”, a person who, at common law, is not considered to be an employee and
3841 whose primary source of income is derived from the pursuit of a bona fide business.

3842 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
3843 business, which is not a health insurance plan and in which the business is liable for the actual
3844 costs of the health care services provided by the plan and administrative costs.

3845 “Social service program”, a social, mental health, developmental disabilities, habilitative,
3846 rehabilitative, substance abuse, residential care, adult or adolescent day care, vocational,
3847 employment and training or elder service program or accommodations purchased by a
3848 governmental unit or political subdivision of the executive office of health and human services,
3849 but excluding any program, service or accommodation that: (i) is reimbursable under a Medicaid

3850 waiver granted under section 1115 of Title XI of the federal Social Security Act; or (ii) is funded
3851 exclusively by a federal grant.

3852 “Social service program provider”, a provider of social service programs in the
3853 commonwealth.

3854 “Sole community provider”, any acute hospital which qualifies as a sole community
3855 provider under Medicare regulations or under regulations promulgated by the executive office.
3856 Those regulations shall consider factors including, but not limited to, isolated location, weather
3857 conditions, travel conditions, percentage of Medicare, Medicaid and free care provided and the
3858 absence of other reasonably accessible hospitals in the area; provided, that such hospitals shall
3859 include those which are located more than 25 miles from other such hospitals in the
3860 commonwealth and which provide services for at least 60 per cent of the primary service area.

3861 “Specialty hospital”, an acute hospital which qualifies for an exemption from the
3862 Medicare prospective payment system regulations or an acute hospital which limits its
3863 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to
3864 children or patients under obstetrical care.

3865 “State institution”, a hospital, sanatorium, infirmary, clinic and other such facility owned,
3866 operated or administered by the commonwealth which furnishes general health supplies, care or
3867 rehabilitative services and accommodations.

3868 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX
3869 programs, other governmental payers, insurance companies, health maintenance organizations
3870 and nonprofit hospital service corporations; provided, however, that “third party payer” shall not

3871 include a purchaser responsible for payment for health care services rendered by a hospital,
3872 either to the purchaser or to the hospital.

3873 SECTION 116. Section 9C of said chapter 118E, as appearing in the 2010 Official
3874 Edition, is hereby amended by striking out, in line 145, the words “established by subsection (c)
3875 of section 18 of chapter 118G”.

3876 SECTION 117. Saidn chapter 118E is hereby further amended by inserting after section
3877 9E the following section:-

3878 Section 9F. (a) As used in this section, the following words shall, unless the context
3879 clearly requires otherwise, have the following meanings:

3880 “Dual eligible”, or “dually eligible person”, any person age 21 or older and under age 65
3881 who is enrolled in both Medicare and MassHealth.

3882 “Integrated care organization” or “ICO”, a comprehensive network of medical, health
3883 care and long-term services and supports providers that integrates all components of care, either
3884 directly or through subcontracts and has been contracted with by the executive office of health
3885 and human services and designated an ICO to provide services to dually eligible individuals
3886 under this section.

3887 (b) Members of the MassHealth dual eligible pilot program on ICOs or any successor
3888 program integrating care for dual eligible persons shall be provided an independent community
3889 care coordinator by the ICO or successor organization, who shall be a participant in the
3890 member’s care team. The community care coordinator shall assist in the development of a long-
3891 term support and services care plan. The community care coordinator shall:

3892 (1) participate in initial and ongoing assessments of the health and functional
3893 status of the member, including determining appropriateness for long-term care support and
3894 services, either in the form of institutional or community-based care plans and related service
3895 packages necessary to improve or maintain enrollee health and functional status;

3896 (2) arrange and, with the agreement of the member and the care team, coordinate
3897 appropriate institutional and community long-term supports and services, including assistance
3898 with the activities of daily living and instrumental activities of daily living, housing, home-
3899 delivered meals, transportation and, under specific conditions or circumstances established by
3900 the ICO or successor organization, authorize a range and amount of community-based services;
3901 and

3902 (3) monitor the appropriate provision and functional outcomes of community
3903 long-term care services, according to the service plan as deemed appropriate by the member and
3904 the care team; and track member satisfaction and the appropriate provision and functional
3905 outcomes of community long-term care services, according to the service plan as deemed
3906 appropriate by the member and the care team.

3907 (c) The ICO or successor organization shall not have a direct or indirect financial
3908 ownership interest in an entity that serves as an independent care coordinator. Providers of
3909 institutional or community based long-term services and supports on a compensated basis shall
3910 not function as an independent care coordinator; provided, however, that the secretary may grant
3911 a waiver of this restriction upon a finding that public necessity and convenience require such a
3912 waiver. For the purposes of this section, an organization compensated to provide only evaluation,

3913 assessment, coordination, skills training, peer supports and fiscal intermediary services shall not
3914 be considered a provider of long term services and supports.

3915 SECTION 118. Section 12 of said chapter 118E, as appearing in the 2010 Official
3916 Edition, is hereby amended by striking out, in lines 11 and 12, the words “division of health care
3917 finance and policy” and inserting in place thereof the following words:- center for health
3918 information and analysis.

3919 SECTION 119. Section 13 of said chapter 118E, as so appearing, is hereby amended by
3920 striking out, in lines 3 and 4, the words “division of health care finance and policy established by
3921 chapter one hundred and eighteen G, which shall be called the “division” only for the purposes
3922 of this section and inserting in place thereof the following words:- executive office of health and
3923 human services, which shall be called the “executive office” only for the purposes of this section
3924 or by a governmental unit designated by the executive office.

3925 SECTION 120. Said section 13 of said chapter 118E, as so appearing, is hereby further
3926 amended by striking out, in lines, 9, 15, 18, 20, 22 and 33 the word “division” and inserting in
3927 place thereof, in each instance, the following words:- executive office.

3928 SECTION 121. Said section 13 of said chapter 118E, as so appearing, is hereby further
3929 amended by striking out, in line 25, the word “division” and inserting in place thereof the
3930 following words:- center for health information and analysis.

3931 SECTION 122. Section 13B of said chapter 118E, as so appearing, is hereby further
3932 amended by striking out, in lines 11 and 12, the words “the Massachusetts health care quality and
3933 cost council, established under section 16K of chapter 6A and”.

3934 SECTION 123. Said chapter 118E is hereby amended by inserting after section 13B the
3935 following 10 sections:-

3936 Section 13C. The secretary of the executive office shall establish rates of payment for
3937 health care services; provided, that the secretary may designate another governmental unit to
3938 perform such ratemaking functions. The secretary of the executive office shall have the
3939 responsibility for establishing rates to be paid to providers for health care services by
3940 governmental units, including the division of industrial accidents. The rates shall be adequate to
3941 meet the costs incurred by efficiently and economically operated facilities providing care and
3942 services in conformity with applicable state and federal laws and regulations and quality and
3943 safety standards and which are within the financial capacity of the commonwealth.
3944 Notwithstanding any general or special law or rule or regulation to the contrary, the secretary of
3945 the executive office shall have the responsibility for establishing fair and adequate charges to be
3946 used by state institutions for general health supplies, care and rehabilitative services and
3947 accommodations, which charges shall be based on the actual costs of the state institution
3948 reasonably related, in the circumstances of each institution, to the efficient production of the
3949 services in the institution and shall also have sole responsibility for determining rates paid for
3950 educational assessments conducted or performed by psychologists and trained, certified
3951 educational personnel under the tenth paragraph of section 3 of chapter 71B.

3952 The secretary of the executive office shall have the responsibility for establishing rates of
3953 payment for social service programs which are reasonable and adequate to meet the costs which
3954 are incurred by efficiently and economically operated social service program providers in
3955 providing social service programs in conformity with federal and state law, regulations and
3956 quality and safety standards; provided, that the secretary may designate another governmental

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

Section 13D. The executive office, or a governmental unit designated to perform ratemaking functions by the executive office shall: (i) determine, after public hearing, at least annually for institutional providers, and at least biennially for non-institutional providers, the rates to be paid by each governmental unit to providers of health care services and social service programs, provided, however, that for the purposes of this section, social service program providers shall be treated as non-institutional providers; (ii) determine, after public hearing, at least annually, the rates to be charged by each state institution for general health supplies, care or rehabilitative services and accommodations; (iii) certify to each affected governmental unit the rates so determined; (iv) determine, after public hearing, at least annually, and certify to the division of industrial accidents of the department of labor and industries, rates of payment for general health supplies, care or rehabilitative services and accommodations, which rates shall be paid for services under chapter 152; (v) upon request of the division of insurance, assist the

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

Such rates for nursing homes and rest homes, as defined under section 71 of chapter 111,
shall be established as of October 1 of each year. In setting such rates, the executive office shall
use as base year costs for rate determination purposes the reported costs of the calendar year not
more than 4 years prior to the current rate year, adjusted for reasonableness and to incorporate
any audit findings applicable to said base year costs. In any appeal of rates under section 13E,
the petitioner shall not be permitted to introduce into the records of such an appeal evidence of
costs for any year other than the base year used to establish the rate. Notwithstanding any other
general or special law or regulation to the contrary, except as provided in this chapter, each
governmental unit shall pay to a provider of services and each state institution shall charge as a
provider of health care services, as the case may be, the rates for general health supplies, care
and rehabilitative services and accommodations determined and certified by the executive office.
In establishing rates of payment to providers of services, the executive office shall control rate
increases and shall impose such methods and standards as are necessary to ensure reimbursement
for those costs which must be incurred by efficiently and economically operated facilities and
providers. Such methods and standards may include, but shall not be limited to, the following:
peer group cost analyses; ceilings on capital and operating costs; productivity standards; caps or
other limitations on the utilization of temporary nursing or other personnel services; use of
national or regional indices to measure increases or decreases in reasonable costs; limits on

4003 administrative costs associated with the use of management companies; the availability of
4004 discounts for large volume purchasers; the revision of existing historical cost bases, where
4005 applicable, to reflect norms or models of efficient service delivery; and other means to encourage
4006 the cost-efficient delivery of services. Rates produced using these methods and standards shall be
4007 in conformance with Title XIX, including the upper limit on provider payments.

4008 In determining rates to be paid by governmental units to providers of services, the
4009 executive office shall include as an operating expense of a provider of services any contribution
4010 made in lieu of taxes by such provider of services to a city or town and shall establish by
4011 regulation those expenses treated as business deductions under the Internal Revenue Code, which
4012 shall be included as allowable operating expenses in determining rates of reimbursement. Except
4013 for ceilings or maximum rates of reimbursement, which are determined in accordance with rate
4014 determination methods imposed on nursing homes, any ceiling or maximum imposed by the
4015 executive office upon the rate of reimbursement to be paid to rest homes shall reflect the actual
4016 costs of rest home providers and shall not prevent any such rest home provider from receiving
4017 full payment for costs necessarily incurred in the provision of services in compliance with
4018 federal or state regulations and requirements.

4019 In determining rates to be paid by governmental units to acute-care hospitals, as defined
4020 in section 25B of chapter 111, and any hospital or separate unit of a hospital that provides acute
4021 psychiatric services, as defined in said section 25B, the executive office shall include as an
4022 operating expense the reasonable cost of providing competent interpreter services as required by
4023 section 25J of said chapter 111 or section 23A of chapter 123.

4024 No hospital shall receive reimbursement or payment from any governmental unit for
4025 amounts paid to employees, as salary, or to consultant or other firms, as fees, where the primary
4026 responsibility of the employees or consultants is, either directly or indirectly, to persuade or seek
4027 to persuade the employees of the hospital to support or oppose unionization. Attorney's fees for
4028 services rendered in dealing directly with a union, in advising hospital management of its
4029 responsibilities under the National Labor Relations Act, or for services at an administrative
4030 agency or court or for services by an attorney in preparation for the agency or in court
4031 proceeding shall not be support or opposition to unionization.

4032 The executive office shall establish rates on a prospective basis, subject to rules and
4033 regulations promulgated by the executive office.

4034 In establishing rates for nursing pools under section 72Y of chapter 111, the executive
4035 office shall establish annually the limit for the rate for service provided by nursing pools to
4036 licensed facilities. The executive office shall establish industry-wide class rates for such services
4037 and shall establish separate class rates for services provided to nursing facilities and hospitals.
4038 The executive office shall establish separate rates for registered nurses, licensed practical nurses
4039 and certified nursing assistants. The executive office may establish rates by geographic region.
4040 The rates shall include an allowance for wages, payroll taxes and fringe benefits, which shall be
4041 based upon, and shall not exceed, median wages, payroll taxes and fringe benefits paid to
4042 permanent medical personnel of the same type at health care facilities in the same geographic
4043 region. The rates shall also include an allowance for reasonable administrative expenses and a
4044 reasonable profit factor, as determined by the executive office. The executive office may exempt
4045 from the rates certain categories, as defined by the executive office, of fixed-term employees that
4046 work exclusively at a particular health care facility for a period of at least 90 days and for whose

4047 services there is a contract between a facility and a nursing pool registered with the department
4048 of public health. The executive office shall establish procedures by which nursing pools shall
4049 submit cost reports, which may be subject to audit, to the executive office to establish rates. The
4050 executive office shall determine the nursing pool rate contained in this paragraph by considering
4051 wage and benefit data collected from cost reports received from nursing pools and from health
4052 care facilities and other relevant information gathered through other collection tools or
4053 reasonable methodologies.

4054 Except as otherwise provided in this section any person aggrieved by any rate
4055 determination made under this section shall have a right of appeal as provided under section 13E.

4056 The executive office may enter into such contracts or agreements with the federal
4057 government, a political subdivision of the commonwealth or any public or private corporation or
4058 organization, as it deems necessary; provided, however, that the executive office shall not enter
4059 into any contract or agreement with a private corporation or organization to furnish information
4060 and statistical data to be used by said executive office as its sole basis for setting rates, if such
4061 private corporation or organization is to make or receive payments based upon the rates so set.

4062 Each governmental unit shall cooperate with the executive office at all times in the
4063 furtherance of the executive office's purposes. Each state institution shall permit the executive
4064 office or any designated representatives of the executive office, to examine its books and
4065 accounts and shall file with the executive office from time to time or upon request such data,
4066 statistics, schedules or other information as the executive office may reasonably require.

4067 Each rate established by the executive office shall be a regulation and shall be subject to
4068 review as hereinafter provided. The executive office shall promulgate rules and regulations for

4069 the administration of its duties and the determination of rates as are herein required subject to the
4070 procedures prescribed by chapter 30A. Every rate, classification and other regulation established
4071 by the executive office shall be consistent where applicable with the principles of reimbursement
4072 for provider costs in effect from time to time under Titles XVIII and XIX of the federal Social
4073 Security Act governing reimbursements or grants available to the commonwealth, its
4074 departments, agencies, boards, divisions or political subdivisions for general health supplies, care
4075 and rehabilitative services and accommodations.

4076 In the event that any aggregate rates certified by the executive office exceed the upper
4077 limit of payment in effect for any period under Titles XVIII or Title XIX of the Social Security
4078 Act or any other requirement of said Titles, where applicable, the executive office shall re-
4079 determine and recertify any such aggregate rates in order to bring them into compliance with
4080 such federal requirement for the entire period during which such upper limit is effective.

4081 This section shall not apply to acute or non-acute hospitals; provided, however, that this
4082 section shall apply to acute and non-acute hospitals for services under the workers'
4083 compensation act.

4084 Section 13E. Except for rates established under section 13F, any person, corporation or
4085 other party aggrieved by an interim rate or a final rate established by the executive office or a
4086 governmental unit designated to perform ratemaking functions by the executive office, or by
4087 failure of the executive office to set a rate or to take other action required by law and desiring a
4088 review thereof shall, within 30 days after said rate is filed with the state secretary or may, at any
4089 time, if there is a failure to determine a rate or take any action required by law, file an appeal
4090 with the division of administrative law appeals established by section 4H of chapter 7. Any

4091 appeal filed under this section shall be accompanied by a certified statement that said appeal is
4092 not interposed for delay. On appeal, the rate determined for any provider of services shall be
4093 adequate, fair and reasonable for such provider, based upon, the costs of such provider, but not
4094 limited thereto.

4095 On an appeal from an interim rate or a final rate the division of administrative law
4096 appeals shall conduct an adjudicatory proceeding under chapter 30A, and said division shall file
4097 its decision with the secretary of the executive office and the state secretary within 30 days after
4098 the conclusion of the hearing.

4099 Said decision shall contain a statement of the reasons for such decision, including a
4100 determination of each issue of fact or law upon which such decision was based. If such decision
4101 results in a recommendation for a rate different from that certified, the executive office shall
4102 establish a new rate based upon such statement of reasons. If the secretary of the executive office
4103 determines that the statement of reasons is inadequate to determine a fair, reasonable and
4104 adequate rate, it may remand the appeal to the hearing officer for further investigation. Any party
4105 aggrieved by a decision of the division may, within 30 days of the receipt of such decision, file a
4106 petition for review in superior court for the county of Suffolk, which shall have exclusive
4107 jurisdiction of such review.

4108 A provider may appeal as an aggrieved party under the preceding sentence, in the event
4109 that a remand by the executive office to a hearing officer does not result in a final decision by the
4110 executive office within 21 days of the date of remand.

4111 The petition shall set forth the grounds upon which the decision of the division should be
4112 set aside. The aggrieved party shall, within 7 days after the petition for review is filed, notify the

4113 executive office and all the parties to the appeal before said division that a petition for review has
4114 been filed by sending each a copy thereof. Within 40 days after the petition for review is filed, or
4115 within such further time as the court may allow, the division of administrative law appeals shall
4116 file in court the original or a certified copy of the record under review. The court may affirm,
4117 modify or set aside the decision of the executive office in whole or in part, remand the decision
4118 to the executive office for further proceedings or enter such other order as justice may require.
4119 Nothing in this section shall be construed to prevent the division from granting temporary relief
4120 if, in its discretion, such relief is justified nor, from informally adjusting or settling controversies
4121 with the consent of all parties.

4122 Judicial review shall be governed by section 14 of chapter 30A to the extent not
4123 inconsistent with this section.

4124 Section 13E ½. All purchasers and third party payers, excluding purchasers and payers
4125 under the workers' compensation act, except as provided in chapter 152, may enter into
4126 contractual arrangements with acute and non-acute hospitals for services. No such arrangement,
4127 including, but not limited to, prices or charges which may be charged for non-contracted services
4128 or which may be negotiated in individual contracts between such purchasers or third party payers
4129 and such acute or non-acute hospitals, shall be subject to prior approval by any public agency;
4130 provided, however, that nothing in this chapter shall limit the authority of the executive office to
4131 establish rates of payment for all health care services adjudged compensable under chapter 152,
4132 and provided, further, that charges established by an acute or non-acute hospital for health care
4133 services rendered shall be uniform for all patients receiving comparable services.

4134 Any acute or non-acute hospital that makes a charge or accepts payment based upon a
4135 charge in excess of that filed, required or approved by the executive office or that fails to file any
4136 data, statistics or schedules or other information required under this chapter or by any regulation
4137 promulgated by the executive office or which falsifies the same, shall be subject to a civil
4138 penalty of not more than \$1,000 for each day on which such violation occurs or continues, which
4139 penalty may be assessed in an action brought on behalf of the commonwealth in any court of
4140 competent jurisdiction. The attorney general shall bring any appropriate action, including
4141 injunctive relief, as may be necessary for the enforcement of this chapter.

4142 Section 13F. All rates of payment to acute hospitals and non-acute hospitals under Title
4143 XIX shall be established by contract between the provider of such hospital services and the
4144 office of Medicaid, except as provided in subsections (a) and (b), or otherwise permitted by law.
4145 All rates shall be subject to all applicable Title XIX statutory and regulatory requirements and
4146 shall include reimbursement for the reasonable cost of providing competent interpreter services
4147 under section 25J of chapter 111 or section 23A of chapter 123.

4148 All such rates for non-acute hospitals shall be effective as of the date specified in section
4149 13A, unless otherwise specified by law.

4150 (a) For disproportionate share hospitals, the executive office shall establish rates that
4151 equal the financial requirements of providing care to recipients of medical assistance.

4152 (b) The executive office, or governmental unit designated by the executive office, shall
4153 establish rates of payment which shall apply to emergency services and continuing emergency
4154 care provided in acute hospitals to medical assistance program recipients, including examination
4155 or treatment for an emergency medical condition or active labor in women or any other care

4156 rendered to the extent required by 42 USC 1395(dd), unless such services are provided under an
4157 agreement between the office of Medicaid and the acute hospital. Such rates of payment shall
4158 reflect the reasonable costs of providing such care, including the costs of providing competent
4159 interpreter services under section 25J of chapter 111 or section 23A of chapter 123 and shall take
4160 into account the characteristics of the hospital in which such care is provided, including, but not
4161 limited to, its status as a teaching hospital, specialty hospital, disproportionate share hospital,
4162 pediatric hospital, pediatric specialty unit or sole community provider. An acute hospital shall,
4163 when a medical assistance program recipient requires post emergency room care and, after
4164 screening and stabilizing the patient's condition, notify the office of Medicaid or its designated
4165 representative and assist said office, to the extent possible, in transferring the recipient to an
4166 appropriate medical setting under said office's direction. Nothing in this section shall be
4167 construed to require the hospital to breach its obligation under said 42 USC 1395(dd) or require
4168 the recipient to forego any right to refuse transfer under said 42 USC 1395(dd). If an acute
4169 hospital is unable or prohibited by law or regulation from transferring the patient under said
4170 office's direction, said executive office shall pay for any and all care associated with such
4171 patient's treatment including, but not limited to, care or services provided in the emergency room
4172 or in an inpatient or outpatient setting. Whenever said office is required to pay for such care
4173 rendered in a non-emergency room setting, said office shall pay all reasonable costs for such
4174 services in such hospital, as determined by the executive office under this chapter and consistent
4175 with Title XIX laws.

4176 No acute hospital may charge to a governmental unit for services provided to publicly
4177 aided patients at a rate higher than the rate payable by the office of Medicaid under Title XIX for

4178 the same service, unless such service is provided by said office under a unique arrangement such
4179 as a selective contract or a managed care contract.

4180 Nothing in this chapter shall be construed to conflict with a waiver of otherwise
4181 applicable federal requirements which the office of Medicaid may obtain from the secretary of
4182 health and human services to implement a primary care case management system for delivering
4183 services, or to implement any other type of managed care service delivery system in which the
4184 eligible recipient is directed to obtain services exclusively from 1 provider or 1 group of
4185 providers.

4186 If the office of Medicaid, contracts with any third party payer for the provision of medical
4187 benefits for medical assistance recipients under Title XIX, said office shall assure that on a
4188 quarterly basis such contracted third party payers notify each acute hospital of the number of
4189 inpatient days of service provided by the hospital to such recipients covered by such contracts.

4190 (c) The executive office, or a governmental unit designated to perform ratemaking
4191 functions by the executive office, shall establish rates of payment which shall apply to
4192 community hospitals located in rural and isolated areas where access to other such providers is
4193 not reasonably available. Such hospitals, specially designated by the commonwealth as sole
4194 community providers, shall receive payment rates calculated to reflect the rural characteristics of
4195 such community hospital and the essential nature of the services provided, which rates shall not
4196 be less than 97 per cent of such hospitals' reasonable financial requirements.

4197 Section 13G. The executive office, or a governmental unit designated to perform
4198 ratemaking functions by the executive office, shall not consider the following as resources of
4199 such hospitals in the establishment, review or approval of acute and non-acute hospital rates and

4200 charges: restricted and unrestricted grants; gifts; contributions; bequests; fund principle; term
4201 endowments and endowment balances; restricted gifts; unrestricted gifts; and all income from
4202 any of the foregoing, including unrestricted income from endowment funds and income and
4203 gains from investment of unrestricted funds. The following words shall have the following
4204 meanings as used in this paragraph:

4205 “Income and gains from investment of unrestricted funds”, interest, dividends, rents or
4206 other income on investments, including net gains or losses resulting from investment
4207 transactions.

4208 “Term endowment”, funds available upon termination of restrictions.

4209 “Unrestricted gifts”, gifts, grants, contributions and bequests, upon which there are no
4210 restrictions imposed by the donor.

4211 “Unrestricted income from endowment funds”, income earned on investment of
4212 endowment funds which have no restrictions on income.

4213 An acute or non-acute care hospital aggrieved by any action or failure to act by the
4214 executive office under this chapter may file an appeal under section 13E.

4215 Section 13H. No acute hospital shall deny access to care and services which the hospital
4216 would provide under this chapter to recipients of benefits under chapter 117A.

4217 Section 13I. Notwithstanding any provisions of this chapter to the contrary, all costs and
4218 charges for patients who are residents of other countries shall, as provided herein, be exempted
4219 from the limitations imposed by this chapter. Any hospital shall be allowed to impose a
4220 surcharge on the normal charges that would otherwise be allowed for such residents of other

4221 countries. Such surcharges shall not be included in the calculation of gross patient service
4222 revenues. The normal charge and the patient discharge statistics shall otherwise be included
4223 under this chapter.

4224 Section 13J. A health maintenance organization organized under chapter 176G may; (i)
4225 negotiate directly with any hospital with respect to such health maintenance organization's rate
4226 of payment for hospital services; and (ii) enter into an agreement with such hospital reflecting
4227 such rate of payment without the approval of the executive office. The specification in this
4228 section of contracting rights of health maintenance organizations shall not be construed as
4229 affirming or denying such rights with respect to any other third party payer.

4230 Section 13K. Upon petition of a receiver appointed under section 72 N of chapter 111,
4231 the executive office shall, under regulations to be promulgated hereunder, adjust the facility's
4232 rate, if necessary, to insure compensation of the receiver and payment for a bond. Such
4233 adjustment shall not be in effect if the licensee is under the jurisdiction of the United States
4234 Bankruptcy Court.

4235 SECTION 124. Section 14 of said chapter 118E, as appearing in the 2010 Official
4236 Edition, is hereby amended by striking out, in lines 4 and 5 and 66, the words "division of health
4237 care finance and policy" and inserting in place thereof, in each instance, the following words:-
4238 executive office of health and human services or a governmental unit designated by the executive
4239 office.

4240 SECTION 125. Section 17A of said chapter 118E, as so appearing, is hereby amended by
4241 striking out, in lines 60 and 62, the word "physician" and inserting in place thereof, in each
4242 instance, the following word:- provider.

4243 SECTION 126. Subsection (e) of section 22 of said chapter 118E, as so appearing, is
4244 hereby amended by striking out, in lines 46 and 47, the words “36 of chapter 118G” and
4245 inserting in place thereof the following figure:- 66.

4246 SECTION 127. Subsection (k) of said section 22 of said chapter 118E, as so appearing, is
4247 hereby amended by striking out, in lines 93 and 96, the word “118G” and inserting in place
4248 thereof, in each instance, the following word:- 118E.

4249 SECTION 128. Said section 22 of said chapter 118E, as so appearing, is hereby further
4250 amended by striking out, in lines 44 and 45, 65, 71, 86 and 87 and 110, the words “division of
4251 health care finance and policy” and inserting in place thereof, in each instance, the following
4252 words:- executive office of health and human services.

4253 SECTION 129. Subsection (m) of said section 22 of said chapter 118E, as so appearing,
4254 is hereby amended by striking out, in lines 112 and 113, the words “39 of chapter 118G” and
4255 inserting in place thereof the following figure:- 69.

4256 SECTION 130. Section 23 of said chapter 118E, as so appearing, is hereby amended by
4257 striking out, in line 74, the words “39 of chapter 118G” and inserting in place thereof the
4258 following figure:- 69.

4259 SECTION 131. Said chapter 118E is hereby further amended by inserting after section 62
4260 the following 15 sections:—

4261 Section 63. (a) For the purposes of this section, the following words shall, unless the
4262 context clearly requires otherwise, have the following meanings:

4263 “Assessment”, the user fee imposed under this section; provided, that for all nursing
4264 homes, the user fee shall be imposed per non-Medicare reimbursed patient day; and provided,
4265 further that a Medicare-reimbursed patient day shall be a Medicare Part A patient day paid for
4266 under either an indemnity fee-for-service arrangement or a Medicare health maintenance
4267 organization contract.

4268 “Nursing home”, a nursing home or a distinct part of a nursing unit of a hospital or other
4269 facility licensed by the department of public health under section 71 of chapter 111.

4270 “Patient day”, a day of care provided to an individual patient by a nursing home.

4271 (b) Each nursing home shall pay an assessment per non-Medicare reimbursed patient day.
4272 The assessment shall be sufficient in the aggregate to generate \$145 million in each fiscal year.
4273 The assessment shall be implemented as a broad based health care-related fee as defined in 42
4274 U.S.C. § 1396b(w)(3)(B). The assessment shall be paid to the executive office quarterly. The
4275 executive office may promulgate regulations that authorize the assessment of interest on any
4276 unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees at a
4277 rate not to exceed 5 per cent per month. The receipts from the assessment, any federal financial
4278 participation received by the commonwealth as a result of expenditures funded by these
4279 assessments and interest thereon shall be credited to the General Fund.

4280 (c) The secretary of the executive office shall prepare a form on which each nursing
4281 home shall report quarterly its total patient days and shall calculate the assessment due. The
4282 secretary of the executive office shall distribute the forms to each nursing home at least annually.
4283 The failure to distribute the form or the failure to receive a copy of the form shall not stay the
4284 obligation to pay the assessment by the date specified in this section. The executive office may

4285 require additional reports, including but not limited to, monthly census data, as it considers
4286 necessary to monitor collections and compliance.

4287 (d) The executive office shall have the authority to inspect and copy the records of a
4288 nursing home to audit its calculation of the assessment. In the event that the executive office
4289 determines that a nursing home has either overpaid or underpaid the assessment, the executive
4290 office shall notify the nursing home of the amount due or refund the overpayment. The executive
4291 office may impose per diem penalties if a nursing home fails to produce documentation as
4292 requested by the executive office.

4293 (e) In the event that a nursing home is aggrieved by a decision of the executive office as
4294 to the amount due, the nursing home may file an appeal to the division of administrative law
4295 appeals within 60 days of the date of the notice of underpayment or the date the notice was
4296 received, whichever is later. The division of administrative law appeals shall conduct each
4297 appeal as an adjudicatory proceeding under chapter 30A and a nursing home aggrieved by a
4298 decision of the division of administrative law appeals shall be entitled to judicial review under
4299 section 14 of said chapter 30A.

4300 (f) The secretary of the executive office may enforce this section by notifying the
4301 department of public health of unpaid assessments. Within 45 days after notice to a nursing home
4302 of amounts due, the department shall revoke licensure of a nursing home that fails to remit
4303 delinquent fees.

4304 (g) The executive office, in consultation with the office of Medicaid, shall promulgate
4305 regulations necessary to implement this section.

4306 Section 64. As used in sections 64 to 69, inclusive, the following words shall, unless the
4307 context clearly requires otherwise, have the following meanings:

4308 “Acute hospital”, the teaching hospital of the University of Massachusetts medical school
4309 and any hospital licensed under section 51 of chapter 111 and which contains a majority of
4310 medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public
4311 health.

4312 "Allowable reimbursement", payment to acute hospitals and community health centers
4313 for health services provided to uninsured or underinsured patients of the commonwealth under
4314 section 69 and any further regulations promulgated by the health safety net office.

4315 "Ambulatory surgical center", a distinct entity that operates exclusively to provide
4316 surgical services to patients not requiring hospitalization and meets the requirements of the
4317 federal Health Care Financing Administration for participation in the Medicare program.

4318 "Ambulatory surgical center services", services described for purposes of the Medicare
4319 program under 42 U.S.C. 1395k(a)(2)(F)(I); provided that “ambulatory surgical center services”
4320 shall include facility services only and shall not include surgical procedures.

4321 "Bad debt", an account receivable based on services furnished to a patient which: (i) is
4322 regarded as uncollectible, following reasonable collection efforts consistent with regulations of
4323 the office, which regulations shall allow third party payers to negotiate with hospitals to collect
4324 the bad debts of its enrollees; (ii) is charged as a credit loss; (iii) is not the obligation of a
4325 governmental unit or the federal government or any agency thereof; and (iv) is not a
4326 reimbursable health care service.

4327 "Community health center", a health center operating in conformance with the
4328 requirements of Section 330 of United States Public Law 95-626, including all community health
4329 centers which file cost reports as requested by the center for health information and analysis.

4330 "Director", the director of the health safety net office.

4331 "DRG", a patient classification scheme known as diagnosis related grouping, which
4332 provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost
4333 incurred by the hospital.

4334 "Emergency bad debt", bad debt resulting from emergency services provided by an acute
4335 hospital to an uninsured or underinsured patient or other individual who has an emergency
4336 medical condition that is regarded as uncollectible, following reasonable collection efforts
4337 consistent with regulations of the office.

4338 "Emergency medical condition", a medical condition, whether physical, behavioral,
4339 related to a substance use disorder or mental, manifesting itself by symptoms of sufficient
4340 severity, including severe pain, that the absence of prompt medical attention could reasonably be
4341 expected by a prudent layperson who possesses an average knowledge of health and medicine to
4342 result in placing the health of the person or another person in serious jeopardy, serious
4343 impairment to body function or serious dysfunction of any body organ or part or, with respect to
4344 a pregnant woman.

4345 "Emergency services", medically necessary health care services provided to an individual
4346 with an emergency medical condition.

4347 "Financial requirements", a hospital's requirement for revenue which shall include, but
4348 not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of
4349 depreciation of plant and equipment and the reasonable costs associated with changes in medical
4350 practice and technology.

4351 "Fund", the Health Safety Net Trust Fund established under section 66.

4352 "Fund fiscal year", the 12-month period starting in October and ending in September.

4353 "Gross patient service revenue", the total dollar amount of a hospital's charges for
4354 services rendered in a fiscal year.

4355 "Health services", medically necessary inpatient and outpatient services as mandated
4356 under Title XIX of the federal Social Security Act; provided, that "health services" shall not
4357 include: (i) nonmedical services, such as social, educational and vocational services; (ii)
4358 cosmetic surgery; (iii) canceled or missed appointments; (iv) telephone conversations and
4359 consultations; (v) court testimony; (vi) research or the provision of experimental or unproven
4360 procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-
4361 surgery hormone therapy; and (vii) the provision of whole blood, but the administrative and
4362 processing costs associated with the provision of blood and its derivatives shall be payable.

4363 "Managed care organization", a managed care organization, as defined in 42 CFR 438.2,
4364 and any eligible health insurance plan, as defined in section 1 of chapter 118H, that contracts
4365 with MassHealth or the commonwealth health insurance connector authority; provided, however,
4366 that "managed care organization" shall not include a senior care organization, as defined in
4367 section 9D.

4368 "Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge
4369 payors to acute hospitals for health services and ambulatory surgical centers for ambulatory
4370 surgical center services; provided, however, that "payments subject to surcharge" shall not
4371 include: (i) payments, settlements and judgments arising out of third party liability claims for
4372 bodily injury which are paid under the terms of property or casualty insurance policies; and (ii)
4373 payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in
4374 policies issued under chapter 176K or similar policies issued on a group basis; provided further,
4375 that "payments subject to surcharge" shall include payments made by a managed care
4376 organization on behalf of: (1) Medicaid recipients under age 65; and (2) enrollees in the
4377 commonwealth care health insurance program; and provided further, that "payments subject to
4378 surcharge" may exclude amounts established under regulations promulgated by the division for
4379 which the costs and efficiency of billing a surcharge payor or enforcing collection of the
4380 surcharge from a surcharge payor would not be cost effective.

4381 "Pediatric hospital", an acute care hospital which limits services primarily to children and
4382 which qualifies as exempt from the Medicare Prospective Payment system regulations.

4383 "Pediatric specialty unit", a pediatric unit of an acute care hospital in which the ratio of
4384 licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20; provided
4385 that in calculating that ratio, licensed pediatric beds shall include the total of all pediatric service
4386 beds, and the total of all licensed hospital beds shall include the total of all licensed acute care
4387 hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put
4388 forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

4389 "Private sector charges", gross patient service revenue attributable to all patients less
4390 gross patient service revenue attributable to Titles XVIII and XIX, other public-aided patients,
4391 reimbursable health services and bad debt.

4392 "Reimbursable health services", health services provided to uninsured and underinsured
4393 patients who are determined to be financially unable to pay for their care, in whole or part, under
4394 applicable regulations of the office; provided that the health services are services provided by
4395 acute hospitals or services provided by community health centers; and provided further, that such
4396 services shall not be eligible for reimbursement by any other public or private third-party payer.

4397 "Resident", a person living in the commonwealth, as defined by the office by regulation;
4398 provided, however, that such regulation shall not define as a resident a person who moved into
4399 the commonwealth for the sole purpose of securing health insurance under this chapter.
4400 Confinement of a person in a nursing home, hospital or other medical institution shall not in and
4401 of itself, suffice to qualify such person as a resident.

4402 "Surcharge payor", an individual or entity that pays for or arranges for the purchase of
4403 health care services provided by acute hospitals and ambulatory surgical center services provided
4404 by ambulatory surgical centers, as defined in this section; provided, however, that the term
4405 "surcharge payor" shall include a managed care organization; and provided further, that
4406 "surcharge payor" shall not include Title XVIII and Title XIX programs and their beneficiaries or
4407 recipients, other governmental programs of public assistance and their beneficiaries or recipients
4408 and the workers' compensation program established under chapter 152.

4409 "Underinsured patient", a patient whose health insurance plan or self-insurance health
4410 plan does not pay, in whole or in part, for health services that are eligible for reimbursement

4411 from the health safety net trust fund, provided that such patient meets income eligibility
4412 standards set by the office.

4413 "Uninsured patient", a patient who is a resident of the commonwealth, who is not covered
4414 by a health insurance plan or a self-insurance health plan and who is not eligible for a medical
4415 assistance program.

4416 Section 65. (a) There shall be established within the office of Medicaid a health safety net
4417 office which shall be under the supervision and control of a director. The director shall be
4418 appointed by the secretary of the executive office and shall be a person of skill and experience in
4419 the field of health care finance and administration. The director shall be the executive and
4420 administrative head of the office and shall be responsible for administering and enforcing the law
4421 relative to the office and to each administrative unit of the office. The director shall receive such
4422 salary as may be determined by law, and shall devote full time to the duties of the office. In the
4423 case of an absence or vacancy in the office of the director, or in the case of disability as
4424 determined by the secretary of the executive office, the secretary of the executive office may
4425 designate an acting director to serve as director until the vacancy is filled or the absence or
4426 disability ceases. The acting director shall have all the powers and duties of the director and shall
4427 have similar qualifications as the director.

4428 (b) The office shall have the following powers and duties: (i) to administer the Health
4429 Safety Net Trust Fund, established under section 66, and to require payments to the fund
4430 consistent with acute hospitals' and surcharge payors' liability to the fund, as determined under
4431 sections 67 and 68, and any further regulations promulgated by the office; (ii) to set in
4432 consultation with the office of Medicaid, reimbursement rates for payments from the fund to

4433 acute hospitals and community health centers for reimbursable health services provided to
4434 uninsured and underinsured patients and to disburse monies from the fund consistent with such
4435 rates; provided that the office shall implement a fee-for-service reimbursement system for acute
4436 hospitals; (iii) to promulgate regulations further defining: (1) eligibility criteria for reimbursable
4437 health services; (2) the scope of health services that are eligible for reimbursement by the Health
4438 Safety Net Trust Fund; (3) standards for medical hardship; and (4) standards for reasonable
4439 efforts to collect payments for the costs of emergency care; provided that the office shall verify
4440 eligibility using the eligibility system of the office of Medicaid and other appropriate sources to
4441 determine the eligibility of uninsured and underinsured patients for reimbursable health services
4442 and shall establish other procedures to ensure that payments from the fund are made for health
4443 services for which there is no other public or private third party payer, including disallowance of
4444 payments to acute hospitals and community health centers for health services provided to
4445 individuals if reimbursement is available from other public or private sources; (iv) to develop
4446 programs and guidelines to encourage maximum enrollment of uninsured individuals who
4447 receive health services reimbursed by the fund into health care plans and programs of health
4448 insurance offered by public and private sources and to promote the delivery of care in the most
4449 appropriate setting, provided that the programs and guidelines are developed in consultation with
4450 the commonwealth health insurance connector, established under chapter 176Q; and provided
4451 further that these programs shall not deny payments from the fund because services should have
4452 been provided in a more appropriate setting if the hospital was required to provide the services
4453 under 42 U.S.C. 1395 dd; (v) to conduct a utilization review program designed to monitor the
4454 appropriateness of services for which payments were made by the fund and to promote the
4455 delivery of care in the most appropriate setting; and to administer demonstration programs that

4456 reduce health safety net trust fund liability to acute hospitals, including a demonstration program
4457 to enable disease management for patients with chronic diseases, substance abuse and psychiatric
4458 disorders through enrollment of patients in community health centers and community mental
4459 health centers and through coordination between these centers and acute hospitals, provided, that
4460 the office shall report the results of these reviews annually to the joint committee on health care
4461 financing and the house and senate committees on ways and means; (vi) to enter into agreements
4462 or transactions with any federal, state or municipal agency or other public institution or with a
4463 private individual, partnership, firm, corporation, association or other entity and to make
4464 contracts and execute all instruments necessary or convenient for the carrying on of its business;
4465 (vii) to secure payment, without imposing undue hardship upon any individual, for unpaid bills
4466 owed to acute hospitals by individuals for health services that are ineligible for reimbursement
4467 from the Health Safety Net Trust Fund which have been accounted for as bad debt by the
4468 hospital and which are voluntarily referred by a hospital to the department for collection;
4469 provided, however that such unpaid charges shall be considered debts owed to the
4470 commonwealth and all payments received shall be credited to the fund; and provided, further,
4471 that all actions to secure such payments shall be conducted in compliance with a protocol
4472 previously submitted by the office to the joint committee on health care financing; (viii) to
4473 require hospitals and community health centers to submit to the office data that it reasonably
4474 considers necessary; (ix) to make, amend and repeal rules and regulations to effectuate the
4475 efficient use of monies from the Health Safety Net Trust Fund; provided, however, that the
4476 regulations shall be promulgated only after notice and hearing and only upon consultation with
4477 the board of the commonwealth health insurance connector, representatives of the Massachusetts
4478 Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of

4479 Massachusetts Safety Net Hospitals, the Conference of Boston Teaching Hospitals and the
4480 Massachusetts League of Community Health Centers; and (x) to provide an annual report at the
4481 close of each fund fiscal year to the joint committee on health care financing and the house and
4482 senate committees on ways and means, evaluating the processes used to determine eligibility for
4483 reimbursable health services, including the Virtual Gateway. The report shall include, but not be
4484 limited to, the following: (1) an analysis of the effectiveness of these processes in enforcing
4485 eligibility requirements for publicly-funded health programs and in enrolling uninsured residents
4486 into programs of health insurance offered by public and private sources; (2) an assessment of the
4487 impact of these processes on the level of reimbursable health services by providers; and (3)
4488 recommendations for ongoing improvements that will enhance the performance of eligibility
4489 determination systems and reduce hospital administrative costs.

4490 Section 66. (a) There shall be established and set up on the books of the commonwealth
4491 a fund to be known as the Health Safety Net Trust Fund, in this section and in sections 67 to 69,
4492 inclusive, called the fund, which shall be administered by the office. Expenditures from the fund
4493 shall not be subject to appropriation unless otherwise required by law. The purposes of the fund
4494 shall be: (i) to maintain a health care safety net by reimbursing hospitals and community health
4495 centers for a portion of the cost of reimbursable health services provided to low-income,
4496 uninsured or underinsured residents; and (ii) to support a portion of the costs of the Medicaid
4497 program this chapter and the commonwealth care health insurance program under chapter 118H.
4498 The office shall administer the fund using such methods, policies, procedures, standards and
4499 criteria that it deems necessary for the proper and efficient operation of the fund and programs
4500 funded by it in a manner designed to distribute the fund resources as equitably as possible. The

4501 director of the health safety net office shall determine annually the estimated expenses of the
4502 office to administer the fund.

4503 (b) The fund shall consist of all amounts paid by acute hospitals and surcharge payors
4504 under sections 67 and 68; all appropriations for the purpose of payments to acute hospitals or
4505 community health centers for health services provided to uninsured and underinsured residents;
4506 any transfers from the Commonwealth Care Trust Fund, established under section 2000 of
4507 chapter 29; and all property and securities acquired by and through the use of monies belonging
4508 to the fund and all interest thereon. Amounts placed in the fund shall, except for amounts
4509 transferred to the Commonwealth Care Trust Fund, be expended by the office for payments to
4510 hospitals and community health centers for reimbursable health services provided to uninsured
4511 and underinsured residents of the commonwealth, consistent with the requirements of this
4512 section and section 69 and the regulations promulgated by the office; provided, however, that
4513 expenses of the health safety net office under subsection (a) shall be expended annually from the
4514 fund; and provided further, that not more than \$6,000,000 shall be expended annually from the
4515 fund for demonstration projects that use case management and other methods to reduce the
4516 liability of the fund to acute hospitals; and provided further, that any amounts collected from
4517 surcharge payors in any year in excess of \$160,000,000, adjusted to reflect applicable surcharge
4518 credits, shall be transferred to the General Fund to support a portion of the costs of the Medicaid
4519 and commonwealth care health insurance programs. Any annual balance remaining in the fund
4520 after these payments have been made shall be transferred to the Commonwealth Care Trust
4521 Fund. All interest earned on the amounts in the fund shall be deposited or retained in the fund.
4522 The director shall from time to time requisition from the fund amounts that the director considers

4523 necessary to meet the current obligations of the office for the purposes of the fund and estimated
4524 obligations for a reasonable future period.

4525 Section 67. (a) An acute hospital's liability to the fund shall equal the product of: (i) the
4526 ratio of its private sector charges to all acute hospitals' private sector charges; and (ii)
4527 \$160,000,000. Annually, before October 1, the office shall establish each acute hospital's
4528 liability to the fund using the best data available, as determined by the health safety net office
4529 and shall update each acute hospital's liability to the fund as updated information becomes
4530 available. The office shall specify by regulation an appropriate mechanism for interim
4531 determination and payment of an acute hospital's liability to the fund. An acute hospital's
4532 liability to the fund shall in the case of a transfer of ownership be assumed by the successor in
4533 interest to the acute hospital.

4534 (b) The office shall establish by regulation an appropriate mechanism for enforcing an
4535 acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled
4536 payment to the fund. These enforcement mechanisms may include: (i) an offset by the office of
4537 Medicaid of payments on the Title XIX claims of any such acute hospital or any health care
4538 provider under common ownership with the acute care hospital or any successor in interest to the
4539 acute hospital; and (ii) the withholding by the office of Medicaid of the amount of payment owed
4540 to the fund, including any interest and late fees and the transfer of the withheld funds into the
4541 fund. If the office of Medicaid offsets claims payments as ordered by the office, it shall not be
4542 considered to be in breach of contract or any other obligation for the payment of non-contracted
4543 services and providers whose payment is offset under an order of the division shall serve all Title
4544 XIX recipients under the contract then in effect with the office of Medicaid, or, in the case of a
4545 non-contracting or disproportionate share hospital, under its obligation for providing services to

4546 Title XIX recipients under this chapter. In no event shall the office direct the office of Medicaid
4547 to offset claims unless an acute hospital has maintained an outstanding obligation to the fund for
4548 a period longer than 45 days and has received proper notice that the office of Medicaid intends to
4549 initiate enforcement actions under regulations promulgated by the office.

4550 Section 68. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge
4551 on all payments subject to surcharge as defined in section 64. The surcharge shall be distinct
4552 from any other amount paid by a surcharge payor for the services of an acute hospital or
4553 ambulatory surgical center. The surcharge amount shall equal the product of: (i) the surcharge
4554 percentage; and (ii) amounts paid for these services by a surcharge payor. The office shall
4555 calculate the surcharge percentage by dividing \$160,000,000 by the projected annual aggregate
4556 payments subject to the surcharge, excluding projected annual aggregate payments based on
4557 payments made by managed care organizations. The office shall determine the surcharge
4558 percentage before the start of each fund fiscal year and may re-determine the surcharge
4559 percentage before April 1 of each fund fiscal year if the office projects that the initial surcharge
4560 percentage established the previous October will produce less than \$150,000,000 or more than
4561 \$170,000,000 in surcharge payments, excluding payments made by managed care organizations.
4562 Before each succeeding October 1, the office shall re-determine the surcharge percentage
4563 incorporating any adjustments from earlier years. In each determination or redetermination of the
4564 surcharge percentage, the office shall use the best data available as determined by the office of
4565 Medicaid and may consider the effect on projected surcharge payments of any modified or
4566 waived enforcement under subsection (e). The office shall incorporate all adjustments, including,
4567 but not limited to, updates or corrections or final settlement amounts, by prospective adjustment
4568 rather than by retrospective payments or assessments.

4569 (b) Each acute hospital and ambulatory surgical center shall bill a surcharge payor an
4570 amount equal to the surcharge described in subsection (a) as a separate and identifiable amount
4571 distinct from any amount paid by a surcharge payor for acute hospital or ambulatory surgical
4572 center services. Each surcharge payor shall pay the surcharge amount to the office for deposit in
4573 the Health Safety Net Trust Fund on behalf of said acute hospital or ambulatory surgical center.
4574 Upon the written request of a surcharge payor, the office may implement another billing or
4575 collection method for the surcharge payor; provided, however, that the office has received all
4576 information that it requests which is necessary to implement such billing or collection method;
4577 and provided further, that the office shall specify by regulation the criteria for reviewing and
4578 approving such requests and the elements of such alternative method or methods.

4579 (c) The office shall specify by regulation appropriate mechanisms that provide for
4580 determination and payment of a surcharge payor's liability, including requirements for data to be
4581 submitted by surcharge payors, acute hospitals and ambulatory surgical centers.

4582 (d) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
4583 assumed by the successor in interest to the surcharge payor.

4584 (e) The office shall establish by regulation an appropriate mechanism for enforcing a
4585 surcharge payor's liability to the fund if a surcharge payor does not make a scheduled payment to
4586 the fund; provided, however, that the office may, for the purpose of administrative simplicity,
4587 establish threshold liability amounts below which enforcement may be modified or waived. Such
4588 enforcement mechanism may include assessment of interest on the unpaid liability at a rate not to
4589 exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5
4590 per cent per month. Such enforcement mechanism may also include notification to the office of

4591 Medicaid requiring an offset of payments on the claims of the surcharge payor, any entity under
4592 common ownership or any successor in interest to the surcharge payor, from the office of
4593 Medicaid in the amount of payment owed to the fund including any interest and penalties, and to
4594 transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as
4595 ordered by the office, the office of Medicaid shall be considered not to be in breach of contract
4596 or any other obligation for payment of non-contracted services, and a surcharge payor whose
4597 payment is offset under an order of the office shall serve all Title XIX recipients under the
4598 contract then in effect with the executive office of health and human services. In no event shall
4599 the office direct the office of Medicaid to offset claims unless the surcharge payor has
4600 maintained an outstanding liability to the fund for a period longer than 45 days and has received
4601 proper notice that the office intends to initiate enforcement actions under regulations
4602 promulgated by the office.

4603 (f) If a surcharge payor fails to file any data, statistics or schedules or other information
4604 required under this chapter or by any regulation promulgated by the office, the office shall
4605 provide written notice to the payor. If a surcharge payor fails to provide required information
4606 within 14 days after the receipt of written notice, or falsifies the same, the surcharge payor shall
4607 be subject to a civil penalty of not more than \$5,000 for each day on which the violation occurs
4608 or continues, which penalty may be assessed in an action brought on behalf of the
4609 commonwealth in any court of competent jurisdiction. The attorney general shall bring any
4610 appropriate action, including injunctive relief, necessary for the enforcement of this chapter.

4611 Section 69. (a) Reimbursements from the fund to hospitals and community health centers
4612 for health services provided to uninsured and underinsured individuals shall be subject to further
4613 rules and regulations promulgated by the office and shall be made in the following manner:-

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

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

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

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

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

4660 (6) Reimbursements to acute hospitals and community health centers for bad debt
4661 shall be made upon submission of evidence, in a form to be determined by the office, that
4662 reasonable efforts to collect the debt have been made.

4663 (7) The office shall reimburse acute hospitals for health services provided to
4664 individuals based on the payment systems in effect for acute hospitals used by the United States
4665 Department of Health and Human Services Centers for Medicare & Medicaid Services to
4666 administer the Medicare Program under Title XVIII of the Social Security Act, including all of
4667 Medicare's adjustments for direct and indirect graduate medical education, disproportionate
4668 share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of
4669 the annual increase in the Medicare hospital market basket index. The office shall, in
4670 consultation with the office of Medicaid and the Massachusetts Hospital Association, promulgate
4671 regulations necessary to modify these payment systems to account for: (i) the differences
4672 between the program administered by the office and the Title XVIII Medicare program,
4673 including the services and benefits covered; (ii) grouper and DRG relative weights for purposes
4674 of calculating the payment rates to reimburse acute hospitals at rates not less than the rates they
4675 are reimbursed by Medicare; (iii) the extent and duration of covered services; (iv) the
4676 populations served; and (v) any other adjustments to the payment methodology under this section
4677 as considered necessary by the office, based upon circumstances of individual hospitals.

4678 Following implementation of this section, the office shall ensure that the allowable
4679 reimbursement rates under this section for health services provided to uninsured individuals shall
4680 not thereafter be less than rates of payment for comparable services under the Medicare program,
4681 taking into account the adjustments required by this section.

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

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

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

4705 Section 70. As used in sections 70 to 75 inclusive, the following words shall, unless the
4706 context requires otherwise, have the following meanings:—

4707 “Consumer,” a person to whom a personal care attendant provides personal care services.

4708 “PCA quality home care workforce council”, “workforce council” or “the council”, the
4709 Personal Care Attendant quality home care workforce council established in section 71.

4710 “Personal care attendant,” a person, including a personal aide, who has been selected by a
4711 consumer or the consumer’s surrogate to provide personal care services to persons with
4712 disabilities or seniors under the MassHealth personal care attendant program or any successor
4713 program.

4714 “Surrogate”, a consumer’s legal guardian or person identified in a written agreement with
4715 the consumer as responsible for hiring, directing and firing on behalf of the consumer.

4716 Section 71. (a) There shall be a PCA quality home care workforce council which shall be
4717 within the executive office of health and human services but shall not be subject to the control of
4718 the executive office, to ensure the quality of long-term, in-home, personal care by recruiting,
4719 training and stabilizing the work force of personal care attendants.

4720 (b) The PCA quality home care workforce council shall consist of 9 members appointed
4721 under this section. A majority of the members of the council shall be consumers as defined in
4722 this chapter. In making appointments to the council, the governor shall appoint the secretary of
4723 the executive office of health and human services or a designee, who shall serve as chair, the
4724 secretary of labor and workforce development or a designee and 1 member from a slate of 3
4725 consumers recommended by the governor's special advisory commission on disability policy.

4726 The auditor shall appoint 1 member from a slate of 3 consumers recommended by the
4727 developmental disabilities council, 1 member from a slate of 3 consumers recommended by the
4728 Massachusetts office on disability, and 1 member from a slate of 3 consumers recommended by
4729 the statewide independent living council. The attorney general shall appoint 1 member from a
4730 slate of 3 consumers or consumer surrogates recommended by the Massachusetts home care
4731 association, 1 member from a slate of 3 consumers or consumer surrogates recommended by the
4732 Massachusetts council on aging and 1 member chosen by the attorney general. The secretary of
4733 health and human services or a designee and the secretary of labor and workforce development
4734 or a designee shall be permanent members during their term in office. Appointees to the council
4735 shall serve 3-year terms. If a vacancy occurs, the executive officer who made the original
4736 appointment shall appoint a new council member to serve the remainder of the unexpired term
4737 or, in the event that the vacancy occurs as the result of the completion of a term, to serve a full
4738 term, and such appointment shall become immediately effective upon the member taking the
4739 appropriate oath. If the departing council member was appointed under a recommendation made
4740 under this paragraph, the executive officer shall make the new appointment from a slate of 3
4741 recommendations put forth by the entity that originally recommended the departing council
4742 member. Members of the council may serve for successive terms of office. A majority of the
4743 council shall constitute a quorum for the transaction of any business. Members of the council
4744 shall not receive compensation for their council service but members shall be reimbursed for
4745 their actual expenses necessarily incurred in the performance of their duties.

4746 Section 72. (a) The workforce council shall carry out the following duties:

4747 (1) Undertake recruiting efforts to identify and recruit prospective personal care
4748 attendants;

4749 (2) Provide training opportunities, either directly or through contract, for personal
4750 care attendants and consumers;

4751 (3) Provide assistance to consumers and consumer surrogates in finding personal
4752 care attendants by establishing a referral directory of personal care attendants; provided that
4753 before placing a personal care attendant on the referral directory, the workforce council shall
4754 determine that the personal care attendant has met the requirements established by the executive
4755 office in its applicable regulations and has not stated in writing a desire to be excluded from the
4756 directory;

4757 (4) Provide routine, emergency and respite referrals of personal care attendants to
4758 consumers and consumer surrogates who are authorized to receive long-term, in-home personal
4759 care services through a personal care attendant;

4760 (5) Give preference in the recruiting, training, referral and employment of
4761 personal care attendants to recipients of public assistance or other low-income persons who
4762 would qualify for public assistance in the absence of such employment; and

4763 (6) Cooperate with state and local agencies on health and aging and other federal,
4764 state and local agencies to provide the services described and set forth in this section. If the PCA
4765 quality home care workforce council identifies concerns regarding the services being provided
4766 by a personal care attendant, the workforce council shall notify the relevant office.

4767 (b) In determining how best to carry out its duties, the PCA quality home care workforce
4768 council shall identify existing personal care attendant recruitment, training and referral resources
4769 made available to consumers or the consumer's surrogate by other state and local public, private
4770 and nonprofit agencies. The council may coordinate with the agencies to provide a local presence

4771 for the council and to provide consumers or the consumer's surrogate greater access to personal
4772 care attendant recruitment, training and referral resources in a cost-effective manner. Using
4773 requests for proposals or similar processes, the council may contract with the agencies to provide
4774 recruitment, training and referral. The council shall provide an opportunity for consumer
4775 participation in coordination efforts.

4776 (c) The commonwealth shall provide to the council a list of all personal care attendants
4777 who have been paid through the MassHealth personal care attendant program and shall update
4778 the list not less frequently than every 6 months to ensure that the council has a complete and
4779 accurate list at all times.

4780 Section 73. (a) Consumers or the consumer's surrogate shall retain the right to select,
4781 hire, schedule, train, direct, supervise and terminate any personal care attendant providing
4782 services to the consumer or consumer's surrogate. Consumers or the consumer's surrogate may
4783 elect to receive long-term, in-home personal care services from personal care attendants who are
4784 not referred to the consumer or consumer's surrogate by the council.

4785 (b) Personal care attendants shall be considered public employees, as defined by and
4786 solely for the purposes of, chapter 150E and section 17J of chapter 180. Said chapter 150E shall
4787 apply to personal care attendants except to the extent that chapter 150E is inconsistent with this
4788 section, in which case this section shall control. In addition, personal care attendants shall be
4789 treated as state employees solely for the purposes of sections 17A and 17G of chapter 180.
4790 Personal care attendants shall not be considered public employees or state employees for any
4791 purpose other than those set forth in this paragraph. The PCA quality home care workforce
4792 council shall be the employer, as defined by and solely for the purposes of said chapter 150E and

4793 said sections 17A, 17G and 17J of said chapter 180 and deductions under said sections 17A, 17G
4794 and 17J may be made by any entity authorized by the commonwealth to compensate personal
4795 care attendants through the MassHealth personal care attendant program. Personal care
4796 attendants shall not be eligible for benefits through the group insurance commission, the state
4797 board of retirement or the state employee workers' compensation program.

4798 (c) Personal care attendants who are employees of the council under this section shall not
4799 be considered, for that reason, public employees or employees of the council for any other
4800 purpose. Nothing in this chapter shall alter the obligations of the commonwealth or the consumer
4801 to provide their share of social security, federal and state unemployment taxes, Medicare and
4802 worker's compensation insurance under the Federal Insurance Contributions Act, federal and
4803 state unemployment law or the Massachusetts Workers' Compensation Act.

4804 (d) Consistent with section 9A of chapter 150E, no personal care attendant shall engage
4805 in a strike and no personal care attendant shall induce, encourage or condone any strike, work
4806 stoppage, slowdown or withholding of services by any personal care attendant.

4807 (e) The only bargaining unit appropriate for the purpose of collective bargaining shall be
4808 a statewide unit of all personal care attendants. The showing of interest required to request an
4809 election is 10 per cent of the bargaining unit. An intervener seeking to appear on the ballot must
4810 make the same showing of interest.

4811 (f) The council or its contractors, may not be held vicariously liable for the action or
4812 inaction of any personal care attendant, whether or not that personal care attendant was included
4813 on the council's referral directory or referred to a consumer or the consumer's surrogate.

4814 (g) The members of the council shall be immune from any liability resulting from
4815 implementation of sections 70 to 75, inclusive.

4816 Section 74. (a) The PCA quality home care workforce council may make and execute
4817 contracts and all other instruments necessary or convenient for the performance of its duties or
4818 exercise of its powers, including contracts with public and private agencies, organizations,
4819 corporations and individuals to pay them for services rendered or furnished.

4820 (b) The council may offer and provide recruitment, training and referral services to
4821 personal care attendants and consumers of long-term, in-home personal care services other than
4822 statutorily defined personal care attendants and consumers, for a fee to be determined by the
4823 council.

4824 (c) The council may issue rules or regulations, as necessary, for the purpose and policies
4825 of sections 70 to 75, inclusive.

4826 (d) Subject to appropriation, the chairperson of the council with the council's approval
4827 may establish offices, employ and discharge employees, agents and contractors as necessary and
4828 prescribe employees' duties and powers and fix the employees' compensation, incur expenses,
4829 and create such liabilities as are reasonable and proper for the administration of sections 70 to
4830 75, inclusive.

4831 (e) The council may solicit and accept for use any grant of money, services or property
4832 from the federal government, the state or any political subdivision or agency thereof, including
4833 federal matching funds under Title XIX of the federal Social Security Act, and do all things
4834 necessary to cooperate with the federal government, the state, or any political subdivision or
4835 agency thereof, in making an application for any grant.

4836 (f) The council may coordinate its activities and cooperate with similar agencies in other
4837 states.

4838 (g) The council may establish technical advisory committees to assist the council.

4839 (h) The council may keep records and engage in research and the gathering of relevant
4840 statistics.

4841 (i) The council may acquire, hold or dispose of real or personal property, or any interest
4842 therein, and construct, lease or otherwise provide facilities for the activities conducted under
4843 sections 70 to 75, inclusive, but the workforce council may not exercise any power of eminent
4844 domain.

4845 (j) The council may delegate to the appropriate persons the power to execute contracts
4846 and other instruments on its behalf and delegate any of its powers and duties, if consistent with
4847 sections 70 to 75, inclusive.

4848 (k) The council may perform other acts necessary or convenient to execute the powers
4849 expressly granted to it.

4850 Section 75. (a) The council shall conduct a performance review every 2 years, submit a
4851 report of the review to the legislature and the governor and make the report available to the
4852 public upon submission to the governor and the legislature.

4853 (b) The performance review and report shall include an evaluation of the health, welfare
4854 and satisfaction with services provided of the consumers receiving long-term in-home personal
4855 care services from personal care attendants under sections 70 to 75, inclusive, including the
4856 degree to which all required services have been delivered, the degree to which consumers

4857 receiving services from personal care attendants have ultimately required additional or more
4858 intensive services, such as home health care, or have been placed in other residential settings or
4859 nursing homes, the promptness of response to consumer complaints and any other issue
4860 considered to be relevant.

4861 (c) The performance review report shall provide an explanation of the full cost of
4862 personal care services, including the administrative costs of the council, unemployment
4863 compensation, Social Security and Medicare payroll taxes paid and any oversight costs.

4864 (d) The performance review report shall make recommendations to the legislature and the
4865 governor for any amendments to sections 70 to 75, inclusive to further ensure the well-being of
4866 consumers, and the most efficient means of delivering required services.

4867 Section 76. The secretary of the executive office may designate another governmental
4868 unit or units to perform any or all functions set forth in sections 13C to 13K, inclusive, and
4869 sections 64 to 75, inclusive. Such designee specifically may include the center for health
4870 information and analysis established under chapter 12C of the General Laws. The secretary may
4871 effectuate such designation through a memorandum of understanding, nonfinancial
4872 interdepartmental service agreement or similar instrument, and such designee shall be a party to
4873 any such instrument and perform the activities described therein.

4874 Section 77. To the maximum extent possible, the office of Medicaid shall attribute every
4875 member to a primary care provider. Members may change their primary care provider, provided
4876 that the member gives notice to the office of Medicaid.

4877 SECTION 132. Chapter 118G of the General Laws is hereby repealed.

4897 and government agencies according to national standards, the reliable and secure transfer of data
4898 among diverse systems and access to and retrieval of data.

4899 “Longitudinal medical record”, a patient’s lifetime electronic health record whether
4900 located, maintained or stored on a provider server, at a central storage repository, or distributed
4901 in multiple locations but accessible with patient consent.

4902 “Massachusetts eHealth institute” or “institute”, the Massachusetts e-Health institute
4903 established under section 6D of chapter 40J.

4904 “Office of the National Coordinator” or “ONC”, the Office of the National Coordinator
4905 for Health Information Technology within the United States Department of Health and Human
4906 Services.

4907 “Statewide health information exchange”, a health information exchange established,
4908 operated or funded by a governmental entity or entities in the commonwealth.

4909 Section 2. (a) There shall be a health information technology council within the executive
4910 office of health and human services. The council shall coordinate with state agencies, including
4911 the commission, other governmental entities and private stakeholders to develop a statewide
4912 health information exchange. The council shall advise the executive office on design,
4913 implementation, operation and use of the statewide health information exchange and related
4914 infrastructure.

4915 (b) The council shall consist of the following 21 members: the secretary of health and
4916 human services or a designee, who shall serve as the chair; the secretary of administration and
4917 finance or a designee; the executive director of the health policy commission or a designee; the

4918 executive director of the center for health information analysis; the director of the Massachusetts
4919 e-Health Institute; the secretary of housing and economic development or a designee; the director
4920 of the office of Medicaid or a designee; and 14 members who shall be appointed by the governor,
4921 of whom at least 1 shall be an expert in health information technology; 1 shall be an expert in
4922 law and health policy; 1 shall be an expert in health information privacy and security; 1 shall be
4923 from an academic medical center; 1 shall be from a community hospital; 1 shall be from a
4924 community health center; 1 shall be from a long term care facility; 1 shall be a from large
4925 physician group practice; 1 shall be from a small physician group practice; 1 shall be a registered
4926 nurse; 1 shall be from a behavioral health, substance abuse disorder or mental health services
4927 organization; 1 shall represent health insurance carriers; and 2 additional members shall have
4928 experience or expertise in health information technology. The council may consult with all
4929 relevant parties, public or private, in exercising its duties under this section, including persons
4930 with expertise and experience in the development and dissemination of electronic health records
4931 systems, and the implementation of electronic health record systems by small physician groups
4932 or ambulatory care providers, as well as persons representing organizations within the
4933 commonwealth interested in and affected by the development of networks and electronic health
4934 records systems, including, but not limited to, persons representing local public health agencies,
4935 licensed hospitals and other licensed facilities and providers, private purchasers, the medical and
4936 nursing professions, physicians and health insurers, the state quality improvement organization,
4937 academic and research institutions, consumer advisory organizations with expertise in health
4938 information technology and other stakeholders as identified by the secretary of health and human
4939 services. Appointed members of the council shall serve for terms of 2 years or until a successor
4940 is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

Chapter 268A shall apply to all council members, except that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided, however, that such interest or involvement shall be disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided, further, that no member shall be considered to have violated section 4 of said chapter 268A because of the member's receipt of usual and regular compensation from such member's employer during the time in which the member participates in the activities of the council.

Section 3. (a) The executive office shall conduct procurements and enter into contracts for the purchase and development of all hardware and software in connection with the creation and implementation of the statewide health information exchange. The executive office may, in consultation with the council and the commission, oversee the technical aspects of the development, dissemination and implementation of the statewide health information exchange including any modules, applications, interfaces or other technology infrastructure necessary to connect provider electronic health records systems to the statewide health information exchange.

(b) The executive office shall:

(i) in consultation with the council, develop a health information exchange strategic and operating plan;

(ii) implement, operate and maintain the statewide health information exchange;

(iii) develop and implement statewide health information exchange infrastructure, including, without limitation, provider directories, certificate storage, transmission gateways,

4962 auditing systems and any components necessary to connect the statewide health information
4963 exchange to provider electronic health records systems; and

4964 (iv) take all actions necessary to directly manage the Office of the National
4965 Coordinator-HIE Cooperative Agreement and ONC Challenge Grant programs, including the
4966 termination of the current State Designated Entity delegation and the transfer of management
4967 responsibility of said ONC-HIE Cooperative Agreement from the Massachusetts e-Health
4968 Institute to the executive office.

4969 Section 4. In carrying out of this chapter, the council shall consult with various
4970 organizations of regional payers and providers in developing the health information exchange
4971 plan and annual updates and in designing, developing, disseminating and implementing the
4972 health information exchange.

4973 In carrying out this chapter, the executive office shall, to the maximum extent practicable,
4974 adopt policies that are consistent with those relating to similar subject matters adopted by the
4975 Office of the National Coordinator for Health Information Technology of the United States
4976 Department of Health and Human Services; provided, however, that nothing herein shall be
4977 construed to limit the executive office's ability to advance interoperability and other health
4978 information technology beyond the standards adopted by the ONC, including without limitation
4979 any applicable meaningful use standards.

4980 Section 5. (a) The council shall approve all expenditures from the Massachusetts Health
4981 Information Exchange Fund established under section 10. The council, in consultation with the
4982 executive office and institute, shall prepare and annually update a statewide health information

exchange implementation plan. The plan shall contain a budget for the application of funds from the Massachusetts Health Information Exchange Fund.

(b) Components of the plan, as updated, shall be community-based and shall assess a municipality's or region's readiness to implement an interoperable electronic health information exchange within the referral market for a defined patient population.

(c) The plan as updated shall: (i) allow seamless, secure electronic exchange of health information among health care providers, health plans and other authorized users; (ii) provide consumers with secure, electronic access to their own health information; (iii) meet all applicable federal and state privacy and security requirements, including requirements imposed by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R. §§160, 162, 164 and 170.; (iv) establish a method by which patients may choose which of their health care providers may disseminate their individually identifiable information; (v) provide public health reporting capability as required under state law; and (vi) allow reporting of health information other than identifiable patient health information for purposes of such activities as the executive office may consider necessary.

(d) The plan as updated shall be consistent with the mandatory compliance date for implementation of the health information exchange under section 7 and all other requirements of this chapter. Each such plan shall be consistent with the statewide electronic health records plan developed by the institute under subsection (c) of section 6D of of chapter 40J.

Section 6. Every patient shall have electronic access to such patient's health records. The executive office shall ensure that each patient will have secure electronic access to such

5005 patient's electronic health records with each of such patient's providers. The executive office
5006 shall ensure that the design of the statewide health information exchange includes the ability to
5007 transmit copies of electronic health records to patients directly or allow facilities to provide
5008 mechanisms for such patient to access such patient's own electronic health record.

5009 Section 7. All providers in the commonwealth shall implement fully interoperable
5010 electronic health records systems that connect to the statewide health information exchange. The
5011 executive office, in consultation with the institute, shall ensure that the statewide health
5012 information exchange and associated electronic health records systems comply with all state and
5013 federal privacy requirements, including those imposed by the Health Insurance Portability and
5014 Accountability Act of 1996, P.L.104-191, the American Recovery and Reinvestment Act of
5015 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R. §§160, 162 and 164.

5016 Section 8. The executive office shall prescribe by regulation penalties for non-
5017 compliance by healthcare providers with the requirements of section 7; provided, however, that
5018 the executive office may waive penalties for good cause, including, but not limited to lack of
5019 broadband internet access as provided in section 9. Penalties collected under this section shall be
5020 deposited into the Prevention and Wellness Trust Fund, established in section 2G of chapter 111.

5021 Section 9. If a provider is located in a geographic area of the commonwealth that does
5022 not have broadband internet access and, due to lack of such broadband internet access, such
5023 provider is unable to fully comply with the requirements of the health information exchange and
5024 any other health information technology requirements implemented by the executive office under
5025 this chapter, such provider may apply to the executive office for a temporary waiver of any
5026 specific requirement with which it is unable to comply. If the executive office determines that

5027 the provider is unable to comply with a requirement due to the lack of broadband internet access,
5028 the executive office may grant a waiver of such requirement; provided, however, that, upon a
5029 determination by the executive office that broadband internet access has become available to
5030 such provider since the date of the grant of the waiver, the executive office shall notify such
5031 provider of such availability. Within 180 days of such notice, such provider shall take such
5032 actions as are necessary to bring the provider into full compliance with the requirements of the
5033 health information exchange and any other health information technology requirements
5034 implemented by the executive office under this chapter.

5035 Section 10. There shall be established and set up on the books of the executive office the
5036 Massachusetts Health Information Exchange Fund, referred to in this section as the fund, for the
5037 purpose of developing a statewide health information exchange. There shall be credited to the
5038 fund any appropriations, proceeds of any bonds or notes of the commonwealth issued for the
5039 purpose, or other monies authorized by the general court and designated thereto; any federal
5040 grants or loans; any private gifts, grants or donations made available; and any income derived
5041 from the investment of amounts credited to the fund. The executive office shall seek, to the
5042 greatest extent possible, private gifts, grants and donations to the fund. The executive office shall
5043 hold the fund in an account or accounts separate from other funds. The fund shall be
5044 administered by the executive office without further appropriation. Amounts credited to the fund
5045 shall be available for reasonable expenditure by the executive office, subject to the approval of
5046 the council where such approval is required under this chapter, for such purposes as the
5047 executive office determines are necessary to support the dissemination and development of the
5048 statewide health information exchange. The secretary of administration and finance shall transfer
5049 a portion of (i) any money in the E-Health Institute Fund, (ii) any money from the ONC Health

5050 Information Exchange Cooperative Agreement, or (iii) the ONC Health Information Exchange
5051 Challenge Grant programs that is related to the implementation of the statewide health
5052 information exchange.

5053 Section 11. Any plan approved by the executive office and council or the e-Health
5054 institute, including every grantee and implementing organization that receives monies funded in
5055 whole or in part from the e-Health Institute Fund established in section 6E of chapter 40J or the
5056 Massachusetts Health Information Exchange Fund established under section 10, shall:

5057 (1) establish a mechanism to allow patients to opt-in to the health information exchange
5058 and to opt-out at any time;

5059 (2) maintain identifiable health information in physically and technologically secure
5060 environments by means including, but not limited to: prohibiting the storage or transfer of
5061 unencrypted and non-password protected identifiable health information on portable data storage
5062 devices; requiring data encryption, unique alpha-numerical identifiers and password protection;
5063 and other methods to prevent unauthorized access to identifiable health information;

5064 (3) provide patients the option of, upon request to a provider, obtaining a list of
5065 individuals and entities that have accessed their identifiable health information from that
5066 provider;

5067 (4) develop and distribute to authorized users of the health information exchange and to
5068 prospective exchange participants, written guidelines addressing privacy, confidentiality and
5069 security of health information and inform individuals: the information available through the
5070 exchange, who may access their information and the purposes for which their information may
5071 be accessed; and

5072 (5) ensure compliance with all state and federal privacy requirements, including those
5073 imposed by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the
5074 American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45
5075 C.F.R. §§160, 162 and 164.

5076 Section 12. In the event of an unauthorized access to or disclosure of individually
5077 identifiable patient health information by or through the statewide health information exchange
5078 or by or through any technology grantees or implementing organizations funded in whole or in
5079 part from the e-Health Institute Fund established in section 6E of chapter 40J or the
5080 Massachusetts Health Information Exchange Fund established in section 10, the operator of such
5081 exchange or grantee or contractor shall: (i) report the conditions of such unauthorized access or
5082 disclosure as required by the executive office; and (ii) provide notice, as defined in section 1 of
5083 chapter 93H, as soon as practicable, but not later than 10 business days after such unauthorized
5084 access or disclosure, to any person whose patient health information may have been
5085 compromised as a result of such unauthorized access or disclosure, and shall report the
5086 conditions of such unauthorized access or disclosure. Any unauthorized access or disclosures
5087 shall be punishable by the civil penalties under section 16.

5088 Section 13. The ability of any provider to transfer or access all or any part of a patient's
5089 electronic health record under this chapter shall be subject to the patient's election to participate
5090 in the electronic health information exchange as provided in section 11

5091 Section 14. The executive office, the council and the institute shall pursue and maximize
5092 all opportunities to qualify for federal financial participation under the matching grant program
5093 established under the Health Information Technology for Economic and Clinical Health Act of

5094 the American Recovery and Reinvestment Act of 2009, P.L. 111-5. The council shall consult
5095 with the office of Medicaid to maximize all opportunities to qualify any expenditure for any
5096 other federal financial participation.

5097 Section 15. The council shall file an annual report, not later than January 30, with the
5098 joint committee on health care financing, the joint committee on economic development and
5099 emerging technologies, the house and senate committees on ways and means and the clerks of
5100 the house and senate concerning the activities of the council in general and, in particular,
5101 describing the progress to date in developing a statewide health information exchange and
5102 recommending such further legislative action as it deems appropriate.

5103 Section 16. Unauthorized access to or disclosure of individually identifiable patient
5104 health information by or through the statewide health information exchange or by or through any
5105 technology grantees or implementing organizations funded in whole or in part from the from the
5106 e-Health Institute Fund established in section 6E of chapter 40J or the Massachusetts Health
5107 Information Exchange Fund established in section 10, or any associated businesses managing or
5108 in possession of such information, the operator of such exchange or grantee or contractor shall be
5109 subject to fines or penalties as determined by the executive office. The executive office shall
5110 promulgate regulations to assess fair and reasonable fines or penalties.

5111 SECTION 135. Section 14 of chapter 122 of the General Laws, as appearing in the 2010
5112 Official Edition, is hereby amended by striking out, in lines 17 and 18, the words “division of
5113 health care finance and policy” and inserting in place thereof the following words:- executive
5114 office of health and human services or a governmental unit designated by the executive office.

5115 SECTION 136. Section 32 of chapter 123 of the General Laws, as so appearing, is hereby
5116 amended by striking out, in lines 4 and 5, the words “division of health care finance and policy”
5117 and inserting in place thereof the following words:- executive office of health and human
5118 services or a governmental unit designated by the executive office.

5119 SECTION 137. Section 33 of said chapter 123, as so appearing, is hereby amended by
5120 striking out, in lines 20 and 25, the words “division of health care finance and policy” and
5121 inserting in place thereof, in each instance, the following words:- executive office of health and
5122 human services or a governmental unit designated by the executive office.

5123 SECTION 138. Section 16 of chapter 123B of the General Laws, as so appearing, is
5124 hereby amended by striking out, in lines 4 and 5, the words “division of health care finance and
5125 policy” and inserting in place thereof the following words:- executive office of health and human
5126 services or a governmental unit designated by the executive office.

5127 SECTION 139. Chapter 149 of the General Laws is hereby amended by striking out
5128 section 6D ½, as so appearing, and inserting in place thereof the following section:-

5129 Section 6D ½. No employee shall be penalized by an employer as a result of such
5130 employee’s filing of an application to the Health Safety Net Trust Fund or otherwise providing
5131 notice to the executive office of health and human services or to a health care provider in regard
5132 to the need for health care services for that employee that results in the employer being required
5133 to reimburse the fund in whole or in part.

5134 SECTION 140. Said chapter 149 is hereby further amended by striking out section 188,
5135 as so appearing, and inserting in place thereof the following section:—

5136 Section 188. (a) As used in this section, the following words, unless the context clearly
5137 requires otherwise, shall have the following meanings:--

5138 “Authority”, the commonwealth health insurance connector authority.

5139 "Contributing employer", an employer that offers a group health plan, as defined in 26
5140 U.S.C. 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as
5141 defined in regulation by the authority.

5142 "Department", the department of unemployment assistance.

5143 "Employee", an individual employed by an employer subject to this chapter for at least 1
5144 month, provided that for the purpose of this section self-employed individuals shall not be
5145 considered employees.

5146 "Employer", an employing unit as defined in section 1 of chapter 151A or in section 1 of
5147 chapter 152.

5148 (b) To more equitably distribute the costs of health care provided to uninsured residents
5149 of the commonwealth, each employer that: (1) employs 11 or more full-time equivalent
5150 employees in the commonwealth and (2) is not a contributing employer shall pay a per-employee
5151 contribution at a time and in a manner prescribed by the director of unemployment assistance, in
5152 this section called the fair share employer contribution. This contribution shall be pro-rated by a
5153 fraction which shall not exceed 1, the numerator of which is the number of hours worked in the
5154 quarter by all of the employer's employees and the denominator of which is the product of the
5155 number of employees employed by an employer during that quarter multiplied by 500 hours.

5156 (c) The executive director of the authority shall, in consultation with the director of
5157 unemployment assistance, annually determine the fair share employer contribution rate based on
5158 the best available data and under the following provisions:-

5159 (1) The per-user share of private sector liability shall be calculated annually by
5160 dividing the sum of hospital liability and third-party payor liability for uncompensated care, as
5161 defined by law, by the total number of individuals in the most recently completed fiscal year
5162 whose care was reimbursed in whole or in part by the health safety net.

5163 (2) The total number of employees in the most recent fiscal year on whose behalf
5164 health care services were reimbursed in whole or in part by the health safety net, shall be
5165 calculated. In calculating this number, the authority shall use all resources available to enable it
5166 to determine the employment status of individuals for whom reimbursements were made,
5167 including quarterly wage reports maintained by the department of revenue.

5168 (3) The total number of employees as calculated in paragraph (2) shall be adjusted
5169 by multiplying that number by the percentage of employers in the commonwealth that are not
5170 contributing employers, as determined by the authority.

5171 (4) The total cost of liability associated with employees of non- contributing
5172 employers shall be determined by multiplying the number of employees, as calculated in
5173 paragraph (3) by the per-user share of private sector liability as calculated in paragraph (1).

5174 (5) The fair share employer contribution shall be calculated by dividing the total
5175 cost of liability as calculated in paragraph (4) by the total number of employees of employers
5176 that are not contributing employers, as determined by the authority.

5177 (6) The fair share employer contribution, as determined in paragraph (5) shall be
5178 adjusted annually to reflect medical inflation, using an appropriate index as determined by the
5179 authority.

5180 (7) The total dollar amount of health care services provided by physicians to non-
5181 elderly, uninsured residents of the commonwealth for which no reimbursement is made from the
5182 Health Safety Net Trust Fund shall be calculated using a survey of physicians or other data
5183 source that the authority determines is most accurate.

5184 (8) The per-employee cost of uncompensated physician care shall be calculated
5185 by dividing the dollar amount of such services, as calculated in paragraph (7) by the total number
5186 of employees of contributing employers in the commonwealth, as estimated by the authority
5187 using the most accurate data source available, as determined by the authority.

5188 (9) The annual fair share employer contribution shall be calculated by adding the
5189 fair share employer contribution as calculated in paragraph (6) and the per-employee cost of
5190 unreimbursed physician care, as calculated in paragraph (8).

5191 (10) Notwithstanding this section, the total annual fair share employer
5192 contribution shall not exceed \$295 per employee which may be made in a single payment or in
5193 equal amounts semi-annually or quarterly, at the employer's discretion.

5194 (d) The director of unemployment assistance shall determine quarterly each employer's
5195 liability for its fair share employer contribution. The director shall assess each employer liable
5196 for a fair share employer contribution in a quarter an amount based on 25 per cent of the annual
5197 fair share employer contribution rate applicable to that quarterly period and shall implement
5198 penalties for employers who fail to make contributions as required by this section. In order to

5199 reduce the administrative costs of collection of contributions, the director shall, to the extent
5200 possible, use any existing procedures implemented by the department of unemployment
5201 assistance to make similar collections. Amounts collected pursuant to this section shall be
5202 deposited in the Commonwealth Care Trust Fund, established by section 2000 of chapter 29.
5203 Before depositing the amounts, the director may deduct all administrative costs incurred by the
5204 department of unemployment assistance as a result of this section, including an amount as
5205 determined by the United States Secretary of Labor in accordance with federal cost rules. Except
5206 where inconsistent with this section, the terms and conditions of chapter 151A which are
5207 applicable to the payment and collection of contributions shall apply to the same extent to the
5208 payment and collection of any obligation under this section. The department of unemployment
5209 assistance shall promulgate regulations necessary to implement this section.

5210 (e) In promulgating regulations defining the term "contribution" under this section, no
5211 proposed regulation by the authority, except an emergency regulation, shall take effect until 60
5212 days after the proposed regulations have been transmitted to the joint committee on health care
5213 financing and the joint committee on financial services.

5214 SECTION 141. Subsection (b) of said section 188 of said chapter 149, as appearing in
5215 section 140, is hereby amended by striking out the first sentence and inserting in place thereof
5216 the following sentence:-

5217 To more equitably distribute the costs of health care provided to uninsured residents of
5218 the commonwealth, each employer that: (1) employs 21 or more full-time equivalent employees
5219 in the commonwealth and (2) is not a contributing employer shall pay a per-employee

5220 contribution at a time and in a manner prescribed by the director of unemployment assistance, in
5221 this section called the fair share employer contribution.

5222 SECTION 142. Subsection (c) of said section 188 of said chapter 149, as so appearing, is
5223 hereby amended by adding the following clause:-

5224 (11) In calculating the fair share assessment, employees who have qualifying health
5225 insurance coverage from a spouse, parent, veteran's plan, Medicare, or a plan or plans due to
5226 disability or retirement shall not be included in the numerator or denominator for purposes of
5227 determining whether an employer is a contributing employer, as defined by 114.5 CMR 16.02.
5228 The employer shall keep and maintain proof of their employee's insurance status, in a reasonable
5229 manner as defined by the authority.

5230 SECTION 143. Section 1 of chapter 150E of the General Laws, as amended by section
5231 23 of chapter 93 of the acts of 2011, is hereby amended by striking out the words "28 of chapter
5232 118G" and inserting in place thereof the following words:- 70 of chapter 118E.

5233 SECTION 144. Said section 1 of said chapter 150E of the General Laws, as so amended,
5234 is hereby further amended by striking out the words "29 of chapter 118G" and inserting in place
5235 thereof the following words:- 71 of chapter 118E.

5236 SECTION 145. Subsection (c) of section 46 of chapter 151A of the General Laws, as
5237 appearing in the 2010 Official Edition, is hereby amended by striking out clause (7) and inserting
5238 in place thereof the following 2 clauses:-

5239 (7) to the commonwealth health insurance connector, information under an interagency
5240 agreement for the administration and enforcement of sections 17 and 18 of chapter 176Q and for

5241 the administration of the fair share employer contribution requirement under section 188 of
5242 chapter 149.

5243 (7 ½) to the executive office of health and human services, information under an
5244 interagency agreement for the administration and enforcement of paragraph (4) of subsection (a)
5245 of section 69 of chapter 118E.

5246 SECTION 146. Section 13 of chapter 152 of the General Laws, as so appearing, is hereby
5247 amended by striking out, in lines 3 and 4, the words “division of health care finance and policy
5248 under the provisions of chapter one hundred and eighteen G” and inserting in place thereof the
5249 following words:- executive office of health and human services under chapter 118E or a
5250 governmental unit designated by the executive office.

5251 SECTION 147. Said section 13 of said chapter 152, as so appearing, is hereby further
5252 amended by striking out, in lines 9, 10, 16 and 21, the word “division” and inserting in place
5253 thereof, in each instance, the following words:- executive office.

5254 SECTION 148. Said section 13 of said chapter 152, as so appearing, is hereby further
5255 amended by striking out, in lines 22 and 23, the words “one hundred and eighteen G” and
5256 inserting in place thereof the following word:- 118E.

5257 SECTION 149. Said section 13 of said chapter 152, as so appearing, is hereby further
5258 amended by striking out, in line 37 and 38, the words “one hundred and eighteen G” and
5259 inserting in place thereof, in each sentence, the following word:- 118E.

5260 SECTION 150. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby
5261 amended by inserting after the definition of “Net value of policies” the following definition:-

5262 “Primary care provider”, a health care professional qualified to provide general medical
5263 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
5264 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
5265 maintains continuity of care within the scope of practice.

5266 SECTION 152. Section 47B of said chapter 175, as so appearing, is hereby amended by
5267 striking out, in line 46, the word “physician” and inserting in place thereof the following word:-
5268 provider.

5269 SECTION 153. Section 47U of said chapter 175, as so appearing, is hereby amended by
5270 striking out, in lines 62 and 64, the word “physician” and inserting in place thereof, in each
5271 instance, the following word :- provider.

5272 SECTION 154. Section 108 of said chapter 175, as so appearing, is hereby amended by
5273 adding the following clause:—

5274 13. Any policy of accident and sickness shall include a premium rate adjustment based on
5275 employee participation in a qualified wellness program. The division shall determine by
5276 regulation the criteria for a qualified wellness program to determine eligibility for the rate
5277 discount. The criteria may require (i) a minimum participation in the programs by percentage, (ii)
5278 promoting healthy workplace habits, (iii) promoting health screenings, (iv) promoting health
5279 education, and (v) any other criteria that the commissioner of insurance deems reasonable.

5280 SECTION 155. Said chapter 175 is hereby further amended by inserting after section
5281 108J the following 2 sections:—

5282 Section 108L. To the maximum extent possible, carriers that offer any policy of accident
5283 and sickness insurance or any general or blanket policy of insurance shall attribute every member
5284 to a primary care provider. Members may change their primary care provider, provided that the
5285 member gives notice to the carrier.

5286 Section 108M. To the extent permissible under applicable state and federal privacy laws,
5287 carriers shall disclose patient-level data to providers in their network solely for the purpose of
5288 carrying out treatment, coordinating care among providers and managing the care of their own
5289 patient panel; provided, that an individual provider shall only receive patient-level data related to
5290 patients treated by said provider. Patient-level data shall include, but not be limited to, health
5291 care service utilization, medical expenses, and demographics.

5292 The division of insurance shall develop procedures and a standard format for disclosing
5293 such patient-level information. The division may require carriers to disclose such information
5294 through the all-payer claims database established under section 12 of chapter 12C if the division
5295 and the center for health information and analysis determine that the all-payer claims database is
5296 an efficient means to provide such information.

5297 Carriers shall make available to any provider with whom they have entered into an
5298 alternative payment contract, the contracted prices of individual health care services within such
5299 payer's network for the purpose of referrals.

5300 SECTION 158. Chapter 175 of the General Laws is hereby amended by inserting after
5301 section 47AA, the following section:—

5302 Section 47BB. (a) For the purposes of this section, “telemedicine“ as it pertains to the
5303 delivery of health care services, shall mean the use of interactive audio, video or other electronic

5304 media for the purpose of diagnosis, consultation or treatment. “Telemedicine” shall not include
5305 the use of audio-only telephone, facsimile machine or e-mail.

5306 (b) An insurer may limit coverage of telemedicine services to those health care providers
5307 in a telemedicine network approved by the insurer.

5308 (c) A contract that provides coverage for services under this section may contain a
5309 provision for a deductible, copayment or coinsurance requirement for a health care service
5310 provided through telemedicine as long as the deductible, copayment or coinsurance does not
5311 exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

5312 (d) Coverage for health care services under this section shall be consistent with coverage
5313 for health care services provided through in-person consultation.

5314 SECTION 159. Section 5 of chapter 176A of the General Laws, as appearing in the 2010
5315 Official Edition, is hereby amended by striking out, in lines 34 and 35, the words “division of
5316 health care finance and policy, in this section called the division” and inserting in place thereof
5317 the following words:- executive office of health and human services, in this section called the
5318 executive office, or a governmental unit designated by the executive office.

5319 SECTION 160. Section 8A of chapter 176A of the General Laws, as so appearing, is
5320 hereby amended by striking out, in line 41, the word “physician” and inserting in place thereof
5321 the following word:- provider.

5322 SECTION 161. Subsection (c) of said section 8A of chapter 176A, as so appearing, is
5323 hereby amended by adding the following paragraph:-

5324 For the purposes of this subsection, the term “primary care provider” shall mean a health
5325 care professional qualified to provide general medical care for common health care problems
5326 who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care
5327 services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the
5328 scope of practice.

5329 SECTION 162. Paragraph (a) of section 8U of chapter 176A, as so appearing, is hereby
5330 amended by inserting after the definition of “Insured” the following definition:-

5331 “Primary care provider”, a health care professional qualified to provide general medical
5332 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
5333 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
5334 maintains continuity of care within the scope of practice.

5335 SECTION 163. Said section 8U of said chapter 176A, as so appearing, is hereby
5336 amended by striking out, in lines 64 and 66, the word “physician” and inserting in place thereof
5337 the following word in each instance:- provider.

5338 SECTION 164. Section 17 of said chapter 176A, as so appearing, is hereby amended by
5339 striking out, in lines 4 and 10, the words “division of health care finance and policy” and
5340 inserting in place thereof, in each instance, the following words:- center for health information
5341 and analysis.

5342 SECTION 165. Said chapter 176A is hereby further amended by adding the following 2
5343 sections:—

5344 Section 36. To the maximum extent possible, every non-profit hospital service
5345 corporation shall attribute every member to a primary care provider. Members may change their
5346 primary care provider, provided that the member gives notice to the carrier.

5347 Section 37. To the extent permissible under applicable state and federal privacy laws,
5348 every non-profit hospital service corporation shall disclose patient-level data to providers in their
5349 network solely for the purpose of carrying out treatment, coordinating care among providers and
5350 managing the care of their own patient panel; provided, that an individual provider shall only
5351 receive patient-level data related to patients treated by said provider. Patient-level data shall
5352 include, but not be limited to, health care service utilization, medical expenses, and
5353 demographics.

5354 The division of insurance shall develop procedures and a standard format for disclosing
5355 such patient-level information. The division may require every non-profit hospital service
5356 corporation to disclose such information through the all-payer claims database established under
5357 section 12 of chapter 12C if the division and the center for health information and analysis
5358 determine that the all-payer claims database is an efficient means to provide such information.

5359 Non-profit hospital service corporations shall make available to any provider with whom
5360 they have entered into an alternative payment contract, the contracted prices of individual health
5361 care services within such payer's network for the purpose of referrals.

5362 SECTION 166. Section 1 of chapter 176B of the General Laws, as appearing in the 2010
5363 Official Edition, is hereby amended by inserting after the definition of "Participating
5364 optometrist" the following definition:-

5365 “Primary care provider”, a health care professional qualified to provide general medical
5366 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
5367 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
5368 maintains continuity of care within the scope of practice.

5369 SECTION 167. Section 4A of said chapter 176B, as so appearing, is hereby amended by
5370 striking out, in line 43, the word “physician” and inserting in place thereof the following word:-
5371 provider.

5372 SECTION 168. Section 4U of said chapter 176B, as so appearing, is hereby amended by
5373 striking out, in lines 64 and 66, the word “physician” and inserting in place thereof the following
5374 word in each instance:- provider.

5375 SECTION 169. Said chapter 176B is hereby further amended by adding the following 2
5376 sections:-

5377 Section 23. To the maximum extent possible, every medical service corporation shall
5378 attribute every member to a primary care provider. Members may change their primary care
5379 provider, provided that the member gives notice to the carrier.

5380 Section 24. To the extent permissible under applicable state and federal privacy laws,
5381 every medical service corporation shall disclose patient-level data to providers in their network
5382 solely for the purpose of carrying out treatment, coordinating care among providers and
5383 managing the care of their own patient panel; provided, that an individual provider shall only
5384 receive patient-level data related to patients treated by said provider. Patient-level data shall
5385 include, but not be limited to, health care service utilization, medical expenses, and
5386 demographics.

5387 The division of insurance shall develop procedures and a standard format for disclosing
5388 such patient-level information. The division may require every medical service corporation to
5389 disclose such information through the all-payer claims database established under section 12 of
5390 chapter 12C if the division and the center for health information and analysis determine that the
5391 all-payer claims database is an efficient means to provide such information.

5392 Medical service corporations shall make available to any provider with whom they have
5393 entered into an alternative payment contract, the contracted prices of individual health care
5394 services within such payer's network for the purpose of referrals.

5395 SECTION 170. Section 1 of chapter 176G of the General Laws, as so appearing, is
5396 hereby amended by inserting after the definition of "Person" the following definition:-

5397 "Primary care provider", a health care professional qualified to provide general medical
5398 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
5399 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
5400 maintains continuity of care within the scope of practice.

5401 SECTION 171. Section 4M of said chapter 176G, as appearing in the 2010 Official
5402 Edition, is hereby amended by striking out, in line 40, the word "physician" and inserting in
5403 place thereof the following word:- provider.

5404 SECTION 172. Section 5 of said chapter 176G, as so appearing, is hereby amended by
5405 striking out, in lines 59 and 61, the word "physician" and inserting in place thereof, in each
5406 instance, the following word:- provider.

5407 SECTION 173. Chapter 176G of the General Laws is hereby amended by adding the
5408 following 2 sections:—

5409 Section 31. To the maximum extent possible, every health maintenance organization
5410 shall attribute every member to a primary care provider. Members may change their primary care
5411 provider, provided that the member gives notice to the carrier.

5412 Section 32. To the extent permissible under applicable state and federal privacy laws,
5413 every health maintenance organization shall disclose patient-level data to providers in their
5414 network solely for the purpose of carrying out treatment, coordinating care among providers and
5415 managing the care of their own patient panel; provided, that an individual provider shall only
5416 receive patient-level data related to patients treated by said provider. Patient-level data shall
5417 include, but not be limited to, health care service utilization, medical expenses, and
5418 demographics.

5419 The division of insurance shall develop procedures and a standard format for disclosing
5420 such patient-level information. The division may require every health maintenance organization
5421 to disclose such information through the all-payer claims database established under section 12
5422 of chapter 12C if the division and the center for health information and analysis determine that
5423 the all-payer claims database is an efficient means to provide such information.

5424 Health maintenance organizations shall make available to any provider with whom they
5425 have entered into an alternative payment contract, the contracted prices of individual health care
5426 services within such payer's network for the purpose of referrals.

SECTION 174. Subsection (a) of section 3 of chapter 176J, as appearing in the 2010 Official Edition, is hereby amended by striking out paragraph (5) and inserting in place thereof the following paragraph:-

(5) A carrier shall apply a wellness program rate discount that applies to both eligible individuals and eligible small groups who follow those wellness programs that have been approved by the commissioner. If a carrier establishes a wellness program rate discount every eligible insured following the wellness program shall be subject to the applicable wellness program rate discount. The division shall determine by regulation the criteria for qualifying for the rate discount. The criteria may require (i) a minimum participation in the programs by percentage, (ii) promoting healthy workplace habits, (iii) promoting health screenings, (iv) promoting health education and (v) any other criteria that the commissioner of insurance deems reasonable.

SECTION 175. Section 6 of said chapter 176J, as amended by section 20 of chapter 142 of the acts of 2011, is hereby further amended by striking out the figure “90”, each time it appears, and inserting in place thereof the following figure:- 89.

SECTION 176. Said section 6 of said chapter 176J, as so amended, is hereby further amended by striking out the figure “89”, as inserted by section 175, and inserting in place thereof, in each instance, the following figure:- 88.

SECTION 177. Said chapter 176J is hereby further amended by striking out section 11, as appearing in the 2010 Official Edition, and inserting in place thereof the following:-

Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for the delivery of health care services through a closed network of health care providers; and (ii) as

5449 of the close of any preceding calendar year, has a combined total of 5,000 or more eligible
5450 individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans
5451 sold, issued, delivered, made effective or renewed to qualified small businesses or eligible
5452 individuals, shall offer to all eligible individuals and small businesses in at least 1 geographic
5453 area at least 1 plan with either:

5454 (1) a reduced or selective network of providers;

5455 (2) a smart tiering plan in which health services are tiered and member cost sharing is based
5456 on the tier placement of the services; or,

5457 (3) a plan in which providers are tiered and member cost sharing is based on the tier
5458 placement of the provider.

5459 The commissioner of insurance shall annually determine a base premium rate discount of
5460 at least 14 per cent for the reduced or selective or tiered network plan compared to the base
5461 premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-
5462 tiered network of providers. The savings may be achieved by means including, but not limited to:
5463 (i) the exclusion of providers with similar or lower quality based on the standard quality measure
5464 set with higher health status adjusted total medical expenses or relative prices, as determined
5465 under section 10 of chapter 12C; or (ii) increased member cost-sharing for members who utilize
5466 providers for non-emergency services with similar or lower quality based on the standard quality
5467 measure set and with higher health status adjusted total medical expenses or relative prices, as
5468 determined under said section 10 of said chapter 12C.

5469 The commissioner may apply waivers to the base premium rate discount determined by
5470 the commissioner under this section to carriers who receive 80 per cent or more of their incomes

5471 from government programs or which have service areas which do not include either Suffolk or
5472 Middlesex counties and who were first admitted to do business by the division of insurance on
5473 January 1, 1988, as health maintenance organizations under chapter 176G.

5474 (b) A tiered network plan shall only include variations in member cost-sharing between
5475 provider tiers which are reasonable in relation to the premium charged and ensure adequate
5476 access to covered services. Carriers shall tier providers based on quality performance as
5477 measured by the standard quality measure set and by cost performance as measured by health
5478 status adjusted total medical expenses and relative prices. Where applicable quality measures are
5479 not available, tiering may be based solely on health status adjusted total medical expenses or
5480 relative prices or both. Smart tiering plans may take into account the number of services
5481 performed each year by the provider. For smart tiering plans, if a medically necessary and
5482 covered service is available at not more than 5 facilities in the state, as determined by the health
5483 policy commission, that service shall not be placed into the most expensive cost-sharing tier.

5484 The commissioner shall promulgate regulations requiring the uniform reporting of tiering
5485 information, including, but not limited to, requiring at least 90 days before the proposed effective
5486 date of any tiered network plan or any modification in the tiering methodology for any existing
5487 tiered network plan, the reporting of a detailed description of the methodology used for tiering
5488 providers, including: the statistical basis for tiering; a list of providers to be tiered at each
5489 member cost-sharing level; a description of how the methodology and resulting tiers will be
5490 communicated to each network provider, eligible individuals and small groups; and a description
5491 of the appeals process a provider may pursue to challenge the assigned tier level.

5492 (c) The commissioner shall determine network adequacy for a tiered network plan based
5493 on the availability of sufficient network providers in the carrier's overall network of providers.

5494 (d) The commissioner shall determine network adequacy for a selective network plan
5495 based on the availability of sufficient network providers in the carrier's selective network.

5496 (e) In determining network adequacy under this section the commissioner of insurance
5497 may take into consideration factors such as the location of providers participating in the plan and
5498 employers or members that enroll in the plan, the range of services provided by providers in the
5499 plan and plan benefits that recognize and provide for extraordinary medical needs of members
5500 that may not be adequately dealt with by the providers within the plan network.

5501 (f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in
5502 selective and tiered plans not more than once per calendar year except that carriers may
5503 reclassify providers from a higher cost tier to a lower cost tier or add providers to a selective
5504 network at any time. If the carrier reclassifies provider tiers or providers participating in a
5505 selective plan during the course of an account year, the carrier shall provide affected members of
5506 the account with information regarding the plan changes at least 30 days before the changes take
5507 effect. Carriers shall provide information on their websites about any tiered or selective plan,
5508 including but not limited to, the providers participating in the plan, the selection criteria for those
5509 providers and where applicable, the tier in which each provider is classified.

5510 (g) A smart tiering plan shall be a tiering product, which offers a cost-sharing differential
5511 based on services rather than facilities providing services. A service covered in a smart tiering
5512 plan may be reimbursed through bundled payments for acute and chronic diseases.

(h) The division of insurance shall review smart tiering plans in a manner consistent with other products offered in the commonwealth. The division of insurance may disapprove a smart tiering plan if it determines that the carrier differentiated cost-sharing obligations solely based on the provider. There shall be a rebuttable presumption that a plan has violated this subsection if the cost-sharing obligation for all services provided by a provider, including a health care facility, accountable care organization, patient centered medical home, or provider organization, is the same.

(i) The commissioner when reviewing smart tiering plans shall promote the following goals: (1) avoid creating consumer confusion; (2) minimize the administrative burdens on payers and providers in implementing smart tiering plans; and (3) allow patients to get their services in the proper locations.

(j) The division of insurance shall report annually specific findings and legislative recommendations, including the following: (1) the utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section; (2) the extent to which tiered product offerings have reduced health care costs for patients and employers; (3) the effects that tiered product offerings have on patient education relating to health care costs and quality; (4) the effects that tiered product offerings have on patient utilization of local hospitals and the resulting impact on overall state health care costs, including the state's compliance with the health care cost growth benchmark established under section 9 of chapter 6D; (5) opportunities to incentivize tiered product offerings for both health systems and employers. The report shall also include the number of members enrolled by plan type, aggregate demographic, geographic information on all members and the average direct premium claims incurred, as defined in section 6, for selective and tiered network products compared to non-selective and non-tiered

5536 products. The report shall be submitted to clerks of the house of representatives and the senate,
5537 the senate and house committees on ways and means and the joint committee on health care
5538 financing.

5539 SECTION 178. Section 12 of said chapter 176J, as appearing in the 2010 Official
5540 Edition, is hereby amended by striking out, in line 59 and 60, the words “division of health care
5541 finance and policy” and inserting in place thereof the following words:- center for health
5542 information and analysis.

5543 SECTION 179. Said section 12 of said chapter 176J, as so appearing, is hereby further
5544 amended by adding the following subsection:—

5545 (h) Any rates offered by a carrier to a certified group purchasing cooperative under this
5546 section shall be based on those group base premium rates that apply to individuals and small
5547 employer groups enrolling outside the group purchasing cooperative but may differ based on:

5548 (1) a benefit rate adjustment factor that would apply to the certified group
5549 purchasing cooperative product if its covered benefits are different than those that apply outside
5550 the certified group purchasing cooperative;

5551 (2) a cooperative adjustment factor that would reflect the relative difference in
5552 the projected experience of the members projected to be enrolled in health benefit plans through
5553 the certified group purchasing cooperative relative to the projected experience of the members
5554 projected to be enrolled in health benefit plans outside the certified group purchasing
5555 cooperative; or

5556 (3) any other rate adjustment factor resulting in a discount of up to 10 per cent.

5557 Any adjustment greater than 10 per cent shall require prior approval in writing from the
5558 commissioner.

5559 SECTION 180. Said chapter 176J is hereby further amended by adding the following 2
5560 sections:-

5561 Section 16. To the maximum extent possible, carriers shall attribute every member to a
5562 primary care provider. Members may change their primary care provider, provided that the
5563 member gives notice to the carrier.

5564 Section 17. To the extent permissible under applicable state and federal privacy laws,
5565 every carrier shall disclose patient-level data to providers in their network solely for the purpose
5566 of carrying out treatment, coordinating care among providers and managing the care of their own
5567 patient panel; provided, that an individual provider shall only receive patient-level data related to
5568 patients treated by said provider. Patient-level data shall include, but not be limited to, health
5569 care service utilization, medical expenses, and demographics.

5570 The division of insurance shall develop procedures and a standard format for disclosing
5571 such patient-level information. The division may require carriers to disclose such information
5572 through the all-payer claims database established under section 12 of chapter 12C if the division
5573 and the center for health information and analysis determine that the all-payer claims database is
5574 an efficient means to provide such information.

5575 Carriers shall make available to any provider with whom they have entered into an
5576 alternative payment contract, the contracted prices of individual health care services within such
5577 payer's network for the purpose of referrals.

5578 SECTION 181. Section 5 of chapter 176M of the General Laws, as appearing in the 2010
5579 Official Edition, is hereby amended by striking out, in lines 94 to 96, inclusive, the words
5580 “division of health care finance and policy established under chapter one hundred and eighteen
5581 G” and inserting in place thereof the following words:- center for health information and analysis
5582 established under chapter 12C.

5583 SECTION 182. Said section 5 of said chapter 176M, as so appearing, is hereby further
5584 amended by striking out, in line 99, the word “division” and inserting in place thereof the
5585 following word:- center.

5586 SECTION 183. Section 1 of said chapter 176O of the General Laws, as so appearing, is
5587 hereby amended by striking out the definition of “Behavioral health manager” and inserting in
5588 place thereof the following definition:-

5589 “Behavioral health manager”, a company, organized under the law of the commonwealth
5590 or organized under the laws of another state and qualified to do business in the commonwealth,
5591 that has entered into a contractual arrangement with a carrier to provide or arrange for the
5592 provision of behavioral, substance use disorder and mental health services to voluntarily enrolled
5593 member of the carrier.

5594 SECTION 184. Said section 1 of said chapter 176O , as so appearing, is hereby further
5595 amended by inserting after the definition of “Division” the following definition:

5596 “Downside risk”, the risk taken on by a provider organization as part of an alternate
5597 payment contract with a carrier or other payer where the provider organization is responsible for
5598 either the full or partial costs of treating a group of patients that exceeds a contract’s budgeted
5599 payment arrangements.

5600 SECTION 185. Said section 1 of said chapter 176O, as so appearing, is hereby further
5601 amended by striking out the definition of “Emergency medical condition” and inserting in place
5602 thereof the following definition:-

5603 “Emergency medical condition”, a medical condition, whether physical, behavioral,
5604 related to substance use disorder, or mental, manifesting itself by symptoms of sufficient
5605 severity, including severe pain, that the absence of prompt medical attention could reasonably be
5606 expected by a prudent layperson who possesses an average knowledge of health and medicine, to
5607 result in placing the health of the insured or another person in serious jeopardy, serious
5608 impairment to body function or serious dysfunction of any body organ or part or, with respect to
5609 a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42
5610 U.S.C. section 1395dd(e)(1)(B).

5611 SECTION 186. Said section 1 of said chapter 176O, as so appearing, is hereby further
5612 amended by striking out the definition of “Health care services” and inserting in place thereof
5613 the following definition:-

5614 “Health care services”, services for the diagnosis, prevention, treatment, cure or relief of
5615 a physical, behavioral, substance use disorder or mental health condition, illness, injury or
5616 disease.

5617 SECTION 187. Said section 1 of said chapter 176O, as so appearing, is hereby further
5618 amended by inserting after the definition of “Person” the following definition:-

5619 “Primary care provider”, a health care professional qualified to provide general medical
5620 care for common health care problems who: (i) supervises, coordinates, prescribes, or otherwise

provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii) maintains continuity of care within the scope of practice.

SECTION 188. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of “Retrospective review” the following definition:-

“Risk-Bearing Provider Organization,” a provider organization that manages the treatment of a group of patients and bears the downside risk according to the terms of an alternate payment contract.

SECTION 189. Section 2 said of chapter 176O, as so appearing, is hereby amended by striking out, in line 22, the word “division” and inserting in place thereof the following word:- center.

SECTION 190. Section 5B of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 11 and 12, the words “the division of health care finance and policy, the health care quality and cost council” and inserting in place thereof the following words:- the center for health information and analysis.

SECTION 191. Said chapter 176O is hereby amended by inserting after section 5B the following section:-

Section 5C. If the commissioner determines that a carrier is neglecting to comply with the coding standards and guidelines under this chapter in the form and within the time required the commissioner shall notify the carrier of such neglect. If the carrier does not come into compliance within a period determined by the commissioner, the carrier shall be fined up to \$5000 for each day during which such neglect continues.

SECTION 192. Subsection (a) of section 6 of said chapter 176O, as appearing in the 2010 Official Edition, is hereby amended by striking out clauses (3) and (4) and inserting in place thereof the following 2 clauses:-

(3) the limitations on the scope of health care services and any other benefits to be provided, including: (i) all restrictions relating to preexisting condition exclusions; (ii) an explanation of any facility fee, allowed amount, co-insurance, copayment, deductible or other amount that the insured may be responsible to pay to obtain covered benefits from network or out-of-network providers; and (iii) the toll-free telephone number and website established by the carrier under section 22 and an explanation of the information that an insured may obtain through such toll-free telephone number and website;

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

5664 SECTION 193. Clause (1) of subsection (a) of section 7 of said chapter 176O, as so
5665 appearing, is hereby amended by striking out, in lines 18 and 19, the words “6 of chapter 118G”
5666 and inserting in place thereof the following words:- 10 of chapter 12C.

5667 SECTION 194. Said section 7 of said chapter 176O, as so appearing, is hereby further
5668 amended by striking out, in lines 20 and 21, the words “6 of said chapter 118G” and inserting in
5669 place thereof the following words:- 10 of said chapter 12C.

5670 SECTION 195. Said section 7 of said chapter 176O, as so appearing in the 2010 Official
5671 Edition, is hereby further amended by striking out, in line 48, the word “physician” and inserting
5672 in place thereof the following word:- provider.

5673 SECTION 196. Section 9A of said chapter 176O, as so appearing, is hereby amended by
5674 striking out, in line 25, the words “6 of chapter 118G” and inserting in place thereof the
5675 following words:- 10 of chapter 12C; and.

5676 SECTION 197. Said section 9A of said chapter 176O, as so appearing, is hereby
5677 amended by adding the following 2 subsections:—

5678 (d) limits the ability of either the carrier or the health care provider from disclosing the
5679 allowed amount and fees of services to an insured or insured’s treating health care provider.

5680 (e) limits the ability of either the carrier or the health care provider from disclosing out-
5681 of-pocket costs to an insured.

5682 SECTION 198. Said chapter 176O is hereby further amended by inserting after section
5683 9A the following section:-

Section 9B. Carriers shall not be permitted to enter into or continue alternate payment arrangements involving downside risk with provider organizations that have not received a risk certificate under chapter 176U.

SECTION 199. Section 12 of said chapter 176O, as appearing in the 2010 Official Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-

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

A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities under said criteria. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria under section 16. Utilization review criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public; provided, however, that a carrier shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization on its website, but must disclose such criteria to a provider or subscriber upon request. If a carrier or utilization review organization intends either to implement a new preauthorization requirement or restriction or amend an existing requirement

5706 or restriction, the carrier or utilization review organization shall ensure that the new or amended
5707 requirement or restriction shall not be implemented unless the carrier's or utilization review
5708 organization's website has been updated to reflect the new or amended requirement or
5709 restriction.

5710 Adverse determinations rendered by a program of utilization review or other denials of
5711 requests for health services, shall be made by a person licensed in the appropriate specialty
5712 related to such health service and, if applicable, by a provider in the same licensure category as
5713 the ordering provider.

5714 SECTION 200. Said section 12 of said chapter 176O, as so appearing, is hereby further
5715 amended by adding the following subsection:-

5716 (f) Upon request by an insured or insured's treating health care provider, a carrier or
5717 utilization review organization shall make a determination regarding whether a proposed
5718 admission, procedure or service is medically necessary within 7 working days of obtaining all
5719 necessary information, except that a carrier or utilization review organization may choose not to
5720 perform such a review if the carrier or utilization review organization determines that the
5721 admission, procedure or service will be covered. Nothing in this subsection shall:- (i) require a
5722 treating health care provider to obtain information regarding whether a proposed admission,
5723 procedure or service is medically necessary on behalf of an insured; (ii) restrict the ability of a
5724 carrier or utilization review organization to deny a claim for an admission, procedure or service
5725 if the admission, procedure or service was not medically necessary, based on information
5726 provided at the time of claim; or (iii) shall restrict the ability of a carrier or utilization review

organization to deny a claim for an admission, procedure or service if other terms and conditions of coverage are not met at the time of service or time of claim.

SECTION 201. Said chapter 176O is hereby further amended by striking out section 15, as so appearing, and inserting in place thereof the following section:—

Section 15. (a) A carrier that allows or requires the designation of a primary care provider shall notify an insured at least 30 days before the disenrollment of such insured's primary care provider and shall permit such insured to continue to be covered for health services, consistent with the terms of the evidence of coverage, by such primary care provider for at least 30 days after said provider is disenrolled, other than disenrollment for quality-related reasons or for fraud. Such notice shall also include a description of the procedure for choosing an alternative primary care provider.

(b) A carrier shall allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, for the period up to and including the insured's first postpartum visit.

(c) A carrier shall allow any insured who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, until the insured's death.

(d) A carrier shall provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a provider who is not a participating provider in

5749 the carrier's network if: (1) the insured's employer only offers the insured a choice of carriers in
5750 which said provider is not a participating provider, and (2) said provider is providing the insured
5751 with an ongoing course of treatment or is the insured's primary care provider. With respect to an
5752 insured in her second or third trimester of pregnancy, this subsection shall apply to services
5753 rendered through the first postpartum visit. With respect to an insured with a terminal illness, this
5754 subsection shall apply to services rendered until death.

5755 (e) A carrier may condition coverage of continued treatment by a provider under
5756 subsections (a) to (d), inclusive, upon the provider's agreeing: (1) to accept reimbursement from
5757 the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to
5758 impose cost sharing with respect to the insured in an amount that would exceed the cost sharing
5759 that could have been imposed if the provider had not been disenrolled; (2) to adhere to the
5760 quality assurance standards of the carrier and to provide the carrier with necessary medical
5761 information related to the care provided; and (3) to adhere to such carrier's policies and
5762 procedures, including procedures regarding referrals, obtaining prior authorization and providing
5763 services under a treatment plan, if any, approved by the carrier. Nothing in this subsection shall
5764 be construed to require the coverage of benefits that would not have been covered if the provider
5765 involved remained a participating provider.

5766 (f) A carrier that requires an insured to designate a primary care provider shall allow such
5767 a primary care provider to authorize a standing referral for specialty health care provided by a
5768 health care provider participating in such carrier's network when (1) the primary care provider
5769 determines that such referrals are appropriate, (2) the provider of specialty health care agrees to a
5770 treatment plan for the insured and provides the primary care provider with all necessary clinical
5771 and administrative information on a regular basis, and (3) the health care services to be provided

5772 are consistent with the terms of the evidence of coverage. Nothing in this section shall be
5773 construed to permit a provider of specialty health care who is the subject of a referral to
5774 authorize any further referral of an insured to any other provider without the approval of the
5775 insured's carrier.

5776 (g) No carrier shall require an insured to obtain a referral or prior authorization from a
5777 primary care provider for specialty care provided by an obstetrician, gynecologist, certified
5778 nurse-midwife or family practitioner participating in such carrier's health care provider network
5779 for the following: (1) annual preventive gynecologic health examinations, including any
5780 subsequent obstetric or gynecological services determined by such obstetrician, gynecologist,
5781 certified nurse-midwife or family practitioner to be medically necessary as a result of such
5782 examination; (2) maternity care; and (3) medically necessary evaluations and resultant health
5783 care services for acute or emergency gynecological conditions. No carrier shall require higher
5784 copayments, coinsurance, deductibles or additional cost sharing arrangements for such services
5785 provided to such insureds in the absence of a referral from a primary care provider. Carriers may
5786 establish reasonable requirements for participating obstetricians, gynecologists, certified nurse-
5787 midwives or family practitioners to communicate with an insured's primary care provider
5788 regarding the insured's condition, treatment and need for follow-up care. Nothing in this section
5789 shall be construed to permit an obstetrician, gynecologist, certified nurse-midwife or family
5790 practitioner to authorize any further referral of an insured to any other provider without the
5791 approval of the insured's carrier.

5792 (h) A carrier shall provide coverage of pediatric specialty care, including mental health
5793 care, by persons with recognized expertise in specialty pediatrics to insureds requiring such
5794 services.

(i) A carrier, including a dental or vision carrier, shall provide health, dental or vision care providers applying to be participating providers who are denied such status with a written reason or reasons for denial of such application.

(j) No carrier shall make a contract with a health care provider which includes a provision permitting termination without cause. A carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment.

(k) A carrier, including a dental or vision carrier, shall provide insureds, upon request, interpreter and translation services related to administrative procedures.

SECTION 202. Section 16 of said chapter 176O, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) A carrier shall be required to pay for health care services ordered by a treating physician or a primary care provider if: (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined in this subsection. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians and participating providers in the carrier's or utilization review organization's service area; (ii) developed under the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured. Any such medical necessity guidelines criteria shall be applied consistently by a carrier or a utilization review organization

5817 and made easily accessible and up-to-date on a carrier or utilization review organization's
5818 website to subscribers, health care providers and the general public. If a carrier or utilization
5819 review organization intends either to implement a new medical necessity guideline or amend an
5820 existing requirement or restriction, the carrier or utilization review organization shall ensure that
5821 the new or amended requirement or restriction shall not be implemented unless the carrier's or
5822 utilization review organization's website has been updated to reflect the new or amended
5823 requirement or restriction.

5824 SECTION 203. Section 20 of said chapter 176O, as so appearing, is hereby amended by
5825 striking out, in lines 19 and 22, the words "care physician" and inserting in place thereof, in each
5826 instance, the following words:- "care provider".

5827 SECTION 204. Section 21 of said chapter 176O, as so appearing, is hereby amended by
5828 striking out, in lines 109 and 110, the words "division of health care finance and policy for use
5829 under section 6 of chapter 118G" and inserting in place thereof the following words:- center for
5830 health information and analysis for use under section 10 of chapter 12C.

5831 SECTION 205. Said section 21 of said chapter 176O, as so appearing, is hereby further
5832 amended by adding the following section:

5833 (e) The commissioner may waive specific reporting requirements in this section for
5834 classes of carriers for which the commissioner deems such reporting requirements to be
5835 inapplicable; provided, however, that the commissioner shall provide written notice of any such
5836 waiver to the joint committee of health care financing and the house and senate committees on
5837 ways and means.

SECTION 206. Said chapter 176O is hereby further amended by adding the following 2 sections:-

Section 23. All carriers shall establish a toll-free telephone number and website that enables consumers to request and obtain from the carrier, within 2 working days, the estimated or maximum allowed amount or charge for a proposed admission, procedure or service and the estimated amount the insured will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the carrier at the time the request is made, including any facility fee, copayment, deductible, coinsurance or other out of pocket amount for any covered health care benefits; provided, that the insured shall not be required to pay more than the disclosed amounts for the covered health care benefits that were actually provided; provided, however, that nothing in this section shall prevent carriers from imposing cost sharing requirements disclosed in the insured's evidence of coverage for unforeseen services that arise out of the proposed admission, procedure or service; and provided further, that the carrier shall alert the insured that these are estimated costs, and that the actual amount the insured will be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

Section 24. (a) All risk-bearing provider organizations certified under chapter 176U shall create internal appeals processes. The appeals processes shall be available to the public in written format and, by request, in electronic format.

(b) The internal appeals processes in subsection (a) shall be completed in a period not longer than 14 days; provided, however, that an expedited internal appeal shall be completed in a period not longer than 3 days for a patient with an urgent medical need including, but not limited

5860 to, terminal illness or emergency situations, as defined through regulations by the office of
5861 patient protection. During the appeals process, the risk-bearing provider organization shall not:
5862 (i) prevent a patient from seeking medical opinions outside of that organization; or (ii) terminate
5863 any medical services being provided to the patient, including medical services which began prior
5864 to the appeal and are the subject of such appeal. The decision on the appeal shall be in writing
5865 and shall notify the patient of the right to file a further external appeal.

5866 (c) Risk-bearing provider organizations shall inform any patient of the right to designate
5867 a third party to advocate on the patient's behalf during the appeals process including, but not
5868 limited to, a spouse or other family member, an attorney of record or a legal guardian. If the
5869 patient does not elect a person to serve as his or her advocate such provider organization shall
5870 offer to contact the office of patient protection and the office of patient protection may designate
5871 an ombudsman to advocate on the patient's behalf.

5872 (d) The office of patient protection shall establish by regulation an external review
5873 process for the review of grievances submitted by or on behalf of patients of risk-bearing
5874 provider organizations. The process shall specify the maximum amount of time for the
5875 completion of a determination and review after a grievance is submitted and shall include the
5876 right to have benefits continued pending appeal. The office of patient protection shall establish
5877 expedited review procedures applicable to emergency and urgent care situations

5878 (e) The office of patient protection shall promulgate regulations necessary to implement
5879 this section.

SECTION 207. Section 23 of chapter 176O, inserted by section 206, is hereby amended by striking out the words “within 2 working days” and inserting in place thereof the following words:- in real time.

SECTION 207A. Chapter 176O is hereby amended by adding the following 3 sections:—

Section 25. (a) A payer or any entity acting for a payer under contract, when requiring prior authorization for a health care service or benefit, shall use and accept only the prior authorization forms designated for the specific types of services and benefits developed under subsection (c).

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

(c) The division shall develop and implement uniform prior authorization forms for different health care services and benefits. The forms shall cover such health care services and benefits including, but not limited to, provider office visits, prescription drug benefits, imaging and other diagnostic testing, laboratory testing and any other health care services. The division shall develop forms for different kinds of services as it deems necessary or appropriate; provided that, all payers and any entities acting for a payer under contract shall use the uniform form designated by the division for the specific type of service. Six months after the full set of forms has been developed, every provider shall use the appropriate uniform prior authorization form to request prior authorization for coverage of the health care service or benefit and every payer or

5902 any entity acting for a payer under contract shall accept the form as sufficient to request prior
5903 authorization for the health care service or benefit.

5904 Nothing in this section shall prohibit a payer or any entity acting for a payer under
5905 contract from using a prior authorization methodology that utilizes an internet webpage, internet
5906 webpage portal, or similar electronic, internet, and web-based system in lieu of a paper form,
5907 provided that it is consistent with the paper form, developed pursuant to subsection (c).

5908 (d) The prior authorization forms developed under subsection (c) shall:

5909 (1) not exceed 2 pages;

5910 (2) be made electronically available; and

5911 (3) be capable of being electronically accepted by the payer after being
5912 completed.

5913 (e) The division, in developing the forms, shall:

5914 (1) seek input from interested stakeholders and shall seek to use forms that have
5915 been mutually agreed upon by payers and providers;

5916 (2) ensure that the forms are consistent with existing prior authorization forms
5917 established by the federal Centers for Medicare and Medicaid Services; and

5918 (3) consider other national standards pertaining to electronic prior authorization.

5919 (f) Nothing in this section shall limit a health plan from requiring prior authorization for
5920 services.

5921 Section 26. The commissioner shall establish standardized processes and procedures
5922 applicable to all health care providers and payers for the determination of a patient's health
5923 benefit plan eligibility at or prior to the time of service. As part of such processes and
5924 procedures, the commissioner shall (i) require payers to implement automated approval systems
5925 such as decision support software in place of telephone approvals for specific types of services
5926 specified by the commissioner and (ii) require establishment of an electronic data exchange to
5927 allow providers to determine eligibility at or prior to the point of care.

5928 Section 27. The division shall develop a common summary of payments form to be used
5929 by all health care payers in the commonwealth that is provided to health care consumers with
5930 respect to provider claims submitted to a payer and written in an easily readable and
5931 understandable format showing the consumer's responsibility, if any, for payment of any portion
5932 of a health care provider claim; provided that the division shall allow the development of forms
5933 to be exchanged through electronic means. The division shall consult with stakeholders to
5934 develop these forms.

5935 SECTION 208. Section 1 of chapter 176Q of the General Laws, as appearing in the 2010
5936 Official Edition, is hereby amended by inserting after the definition of "Connector seal of
5937 approval" the following definition:-

5938 "Dependent", the spouse and children of any employee if such persons would qualify for
5939 dependent status under the Internal Revenue Code or for whom a support order could be granted
5940 under chapters 208, 209 or 209C.

5941 SECTION 209. Said section 1 of said chapter 176Q, as so appearing, is hereby further
5942 amended by striking out the definition of "division".

SECTION 210. Said section 1 of said chapter 176Q, as so appearing, is hereby further amended by inserting after the definition of “Eligible small groups” the following 2 definitions:-

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

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

SECTION 211. Said section 1 of said chapter 176Q, as so appearing, is hereby further amended by inserting after the definition of “Mandated benefits” the following 2 definitions:-

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

5965 “Non-providing employer”, an employer of a state-funded employee, as defined in this
5966 section; provided, however, that the term “non-providing employer” shall not include: (i) an
5967 employer who complies with chapter 151F for such employee; (ii) an employer that is signatory
5968 to or obligated under a negotiated, bona fide collective bargaining agreement between such
5969 employer and bona fide employee representative which agreement governs the employment
5970 conditions of such person receiving free care; (iii) an employer who participates in the insurance
5971 reimbursement program; or (iv) an employer that employs not more than 10 employees;
5972 provided, further, that for the purposes of this definition, an employer shall not be considered to
5973 pay for or arrange for the purchase of health care services provided by acute hospitals and
5974 ambulatory surgical centers by making or arranging for any payments to the uncompensated care
5975 pool.

5976 SECTION 212. Said section 1 of said chapter 176Q, as so appearing, is hereby further
5977 amended by inserting after the definition of “Participating institution” the following definition:-

5978 “Payments from non-providing employers”, all amounts paid to the Uncompensated Care
5979 Trust Fund or the General Fund or any successor fund by non-providing employers.

5980 SECTION 213. Said section 1 of said chapter 176Q is hereby further amended by
5981 inserting after the definition of “Stand-alone vision plan”, inserted by section 39 of chapter 118
5982 of the acts of 2012, the following definition:-

5983 “State-funded employee”, any employed person, or dependent of such person, who
5984 receives, on more than 3 occasions during any hospital fiscal year, health services paid for as free
5985 care; or any employed persons, or dependents of such persons, of a company that has 5 or more
5986 occurrences of health services paid for as free care by all employees in aggregate during any

5987 fiscal year; provided, that an occurrence shall include all healthcare related services incurred
5988 during a single visit to a health care professional.

5989 SECTION 214. Said section 1 of said chapter 176Q, as appearing in the 2010 Official
5990 Edition, is hereby further amended by adding the following definition:-

5991 “Uninsured patient”, a patient who is not covered by a health insurance plan, a self-
5992 insurance health plan or a medical assistance program.

5993 SECTION 215. Said chapter 176Q is hereby further amended by adding the following 2
5994 sections:—

5995 Section 17. (a) The connector shall prepare a form, to be called the employer health
5996 insurance responsibility disclosure, on which an employer shall report whether it is in
5997 compliance with chapter 151F and any other information required by the connector relative to
5998 section 18 and paragraph (4) of subsection (a) of section 69 of chapter 118E. The form shall be
5999 completed, signed and returned to the connector by every employer with 11 or more full-time
6000 equivalent employees.

6001 (b) The connector shall prepare a form, to be called the employee health insurance
6002 responsibility disclosure, on which an employee of employers with 11 or more full-time
6003 equivalent employees who declines an employer-sponsored health plan shall report whether the
6004 employee has an alternative source of health insurance coverage. The form shall be completed
6005 and signed by the employee and shall be retained by the employer for 3 years. The connector
6006 may request a copy of the signed employee form.

6007 (c) Information that identifies individual employees by name or health insurance status
6008 shall not be a public record, but the information shall be exchanged with the department of
6009 revenue, the commonwealth health insurance connector authority and the health care access
6010 bureau in the division of insurance under an interagency services agreement to enforce this
6011 section, sections 3 to 7A, inclusive, and sections 3, 6B and 18B of chapter 118H. An employer
6012 who knowingly falsifies or fails to file with the connector any information required by this
6013 section or by any regulation promulgated by the connector shall be punished by a fine of not less
6014 than \$1,000 and not more than \$5,000.

6015 Section 18. (a) The authority shall, upon verification of the provision of services and
6016 costs to a state-funded employee, assess a free rider surcharge on the non-providing employer
6017 under regulations promulgated by the authority.

6018 (b) The amount of the free rider surcharge on non-providing employers shall be
6019 determined by the authority under regulations promulgated by the authority, and assessed by the
6020 authority not later than 3 months after the end of each hospital fiscal year, with payment by non-
6021 providing employers not later than 180 days after the assessment. The amount charged by the
6022 authority shall be greater than 10 per cent but not greater than 100 per cent of the cost to the state
6023 of the services provided to the state-funded employee, considering all payments received by the
6024 state from other financing sources for free care; provided, that the "cost to the state" for services
6025 provided to any state-funded employee may be determined by the authority as a percentage of
6026 the state's share of aggregate costs for health services. The free rider surcharge shall only be
6027 triggered upon incurring \$50,000 or more, in any hospital fiscal year, in free care services for
6028 any employer's employees, or dependents of such persons, in aggregate, regardless of how many
6029 state-funded employees are employed by that employer.

6030 (c) The formula for assessing free rider surcharges on non-providing employers shall be
6031 set forth in regulations promulgated by the authority that shall be based on factors including, but
6032 not limited to: (i) the number of incidents during the past year in which employees of the non-
6033 providing employer received services reimbursed by the health safety net office under section 69
6034 of chapter 118E; (ii) the number of persons employed by the non-providing employer; and (iii)
6035 the proportion of employees for whom the non-providing employer provides health insurance.

6036 (d) If a state-funded employee is employed by more than 1 non-providing employer at the
6037 time the state-funded employee receives services, the authority shall assess a free rider surcharge
6038 on each said employer consistent with the formula established by the authority under this section.

6039 (e) The authority shall specify by regulation appropriate mechanisms for implementing
6040 free rider surcharges on non-providing employers. Said regulations shall include, but not be
6041 limited to, the following provisions: (i) appropriate mechanisms that provide for determination
6042 and payment of the surcharge by a non-providing employer including requirements for data to be
6043 submitted by employers, employees, acute hospitals and ambulatory surgical centers, and other
6044 persons; and (ii) penalties for nonpayment or late payment by the non-providing employer,
6045 including assessment of interest on the unpaid liability at a rate not to exceed an annual
6046 percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per
6047 month.

6048 (f) All surcharge payments made under this section shall be deposited into the
6049 Commonwealth Care Trust Fund, established under section 2000 of chapter 29.

6050 (g) A non-providing employer's liability to the Commonwealth Care Trust Fund shall, in
6051 the case of a transfer of ownership, be assumed by the successor in interest to the non-providing
6052 employer's interest.

6053 (h) If a non-providing employer fails to file any data, statistics or schedules or other
6054 information required under this chapter or by any regulation promulgated by the authority, the
6055 authority shall provide written notice of the required information. If the employer fails to provide
6056 information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject
6057 to a civil penalty of not more than \$5,000 for each week on which such violation occurs or
6058 continues, which penalty may be assessed in an action brought on behalf of the commonwealth
6059 in any court of competent jurisdiction.

6060 (i) The attorney general shall bring any appropriate action, including injunctive relief, as
6061 may be necessary for the enforcement of this chapter.

6062 (j) No employer shall discriminate against any employee on the basis of the employee's
6063 receipt of free care, the employee's reporting or disclosure of the employer's identity and other
6064 information about the employer, the employee's completion of a Health Insurance Responsibility
6065 Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed
6066 against the employer in relation to the employee. Violation of this subsection shall constitute a
6067 per se violation of chapter 93A.

6068 (k) A hospital, surgical center, health center or other entity that provides uncompensated
6069 care pool services shall provide an uninsured patient with written notice of the criminal penalties
6070 for committing fraud in connection with the receipt of uncompensated care pool services. The
6071 authority shall promulgate a standard written notice form to be made available to health care

providers in English and other languages. The form shall further include written notice of every employee's protection from employment discrimination under this section.

SECTION 216. The General Laws are hereby amended by inserting after chapter 176R the following 2 chapters:-

CHAPTER 176S

CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

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

"Carrier", (1) an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; (2) a nonprofit hospital service corporation organized under chapter 176A; (3) a nonprofit medical service corporation organized under chapter 176B; (4) a health maintenance organization organized under chapter 176G; (5) an organization entering into a preferred provider arrangement under chapter 176I; (6) a contributory group general or blanket insurance for persons in the service of the commonwealth under chapter 32A; (7) a contributory group general or blanket insurance for persons in the service of counties, cities, towns and districts, and their dependents under chapter 32B; (8) the medical assistance program administered by the office of Medicaid pursuant to chapter 118E and in accordance with Title XIX of the Social Security Act or any successor statute; and (9) any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.

"Commissioner", the commissioner of insurance.

6092 “Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a
6093 carrier.

6094 “Nondiscriminatory basis”, a carrier shall be deemed to be providing coverage on a non-
6095 discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service
6096 limitation imposed on coverage for the care provided by a physician assistant which is less than
6097 any annual or lifetime dollar or unit of service limitation imposed on coverage for the same
6098 services by other participating providers.

6099 “Participating provider”, a provider who, under terms and conditions of a contract with
6100 the carrier or with its contractor or subcontractor, has agreed to provide health care services to an
6101 insured with an expectation of receiving payment, other than coinsurance, co-payments or
6102 deductibles, directly or indirectly from the carrier.

6103 “Physician assistant”, a person who is a graduate of an approved program for the training
6104 of physician assistants who is supervised by a registered physician in accordance with sections
6105 9C to 9H, inclusive, of chapter 112, and who has passed the Physician Assistant National
6106 Certifying Exam or its equivalent.

6107 “Primary care provider”, a health care professional qualified to provide general medical
6108 care for common health care problems who (1) supervises, coordinates, prescribes, or otherwise
6109 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
6110 maintains continuity of care within the scope of practice.

6111 Section 2. The commissioner and the group insurance commission shall require that all
6112 carriers recognize physician assistants as participating providers subject to section 3 and shall
6113 include coverage on a nondiscriminatory basis to their insureds for care provided by physician

6114 assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall
6115 include benefits for primary care, intermediate care and inpatient care, including care provided in
6116 a hospital, clinic, professional office, home care setting, long-term care setting, mental health or
6117 substance abuse program, or any other setting when rendered by a physician assistant who is a
6118 participating provider and is practicing within the scope of his or her professional authority as
6119 defined by statute, rule and physician delegation to the extent that such policy or contract
6120 currently provides benefits for identical services rendered by a provider of health care licensed
6121 by the commonwealth.

6122 Section 3. A participating provider physician assistant practicing within the scope of such
6123 physician assistant's license, including all regulations requiring collaboration with or supervision
6124 by a physician under section 9E of chapter 112, shall be considered qualified within the carrier's
6125 definition of primary care provider to an insured.

6126 Section 4. Notwithstanding any general or special law to the contrary, a carrier that
6127 requires the designation of a primary care provider shall provide its insured with an opportunity
6128 to select a participating provider physician assistant as a primary care provider.

6129 Section 5. Notwithstanding any general or special law to the contrary, a carrier shall
6130 ensure that all participating provider physician assistants are included on any publicly accessible
6131 list of participating providers for the carrier.

6132 Section 6. A complaint for noncompliance against a carrier shall be filed with and
6133 investigated by the commissioner or the group insurance commission, whichever shall have
6134 regulatory authority over the carrier. The commissioner and the group insurance commission
6135 shall promulgate regulations to enforce this chapter.

6136 CHAPTER 176T

6137 RISK-BEARING PROVIDER ORGANIZATIONS

6138 Section 1. As used in this chapter the following words shall, unless the context clearly
6139 requires otherwise, have the following meanings:-

6140 “Alternative payment contract”, any contract between a provider or provider organization
6141 and a health care payer payer which utilizes alternative payment methodologies.

6142 “Alternative payment methodologies or methods”, methods of payment that are not solely
6143 based on fee-for-service reimbursements; provided, however, that “alternative payment
6144 methodologies” may include, but shall not be limited to, shared savings arrangement, bundled
6145 payments, and global payments; and further provided, that “alternative payment methodologies”
6146 may include fee-for-service payments, which are settled or reconciled with a bundled or global
6147 payment.

6148 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health
6149 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
6150 176A; a nonprofit medical service corporation organized under chapter 176B; a health
6151 maintenance organization organized under chapter 176G; and an organization entering into a
6152 preferred provider arrangement under chapter 176I, but not including an employer purchasing
6153 coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or
6154 affiliated corporations of the employer; provided, however, that, unless otherwise noted, the term
6155 “carrier” shall not include any entity to the extent it offers a policy, certificate or contract that
6156 provides coverage solely for dental care services or vision care services.

6157 “Center”, the center for health information and analysis established in chapter 12C.

6158 “Commission”, the health policy commission established in chapter 6D.

6159 “Commissioner”, the commissioner of insurance.

6160 “Division”, the division of insurance.

6161 “Downside risk”, the risk taken on by a provider organization as part of an alternate
6162 payment contract with a carrier or other payer in which the provider organization is responsible
6163 for either the full or partial costs of treating a group of patients that may exceed the contracted
6164 budgeted payment arrangements.

6165 “Employer”, an employer as defined in section 1 of chapter 151A.

6166 “Health care services”, supplies, care and services of medical, surgical, optometric,
6167 dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative,
6168 supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital
6169 care and services, provided by a community health center, home health and hospice care
6170 provider, or by a sanatorium, as included in the definition of “hospital” in Title XVIII of the
6171 federal Social Security Act, and treatment and care compatible with such services or by a health
6172 maintenance organization.

6173 “Medicaid program”, the medical assistance program administered by the office of
6174 Medicaid under chapter 118E and in accordance with Title XIX of the Federal Social Security
6175 Act or any successor statute.

6176 “Medical assistance program”, the medicaid program, the Veterans Administration health
6177 and hospital programs and any other medical assistance program operated by a governmental
6178 unit for persons categorically eligible for such program.

6179 “Medical service corporation”, a corporation established to operate a nonprofit medical
6180 service plan as provided in chapter 176B.

6181 “Medicare program”, the medical insurance program established by Title XVIII of the
6182 Social Security Act.

6183 “Provider” or “health care provider”, any person, corporation, partnership, governmental
6184 unit, state institution or any other entity qualified under the laws of the commonwealth to
6185 perform or provide health care services.

6186 “Provider organization”, any corporation, partnership, business trust, association or
6187 organized group of persons in the business of health care delivery or management whether
6188 incorporated or not that represents 1 or more health care providers in contracting with carriers for
6189 the payments of health care services; provided, however, that “provider organization” shall
6190 include, but not be limited to, physician organizations, physician-hospital organizations,
6191 independent practice associations, provider networks, accountable care organizations and any
6192 other organization that contracts with carriers for payment for health care services.

6193 “Public health care payer”, the Medicaid program established in chapter 118E; any
6194 carrier or other entity that contracts with the office of Medicaid or the commonwealth health
6195 insurance connector to pay for or arrange the purchase of health care services on behalf of
6196 individuals enrolled in health coverage programs under Titles XIX or XXI, or under the
6197 commonwealth care health insurance program, including prepaid health plans subject to the

6198 provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission
6199 established under chapter 32A; and any city or town with a population of more than 60,000 that
6200 has adopted chapter 32B.

6201 “Registered provider organization”, a provider organization that has been registered in
6202 accordance with chapter 6D.

6203 “Risk-bearing provider organization”, a provider organization that manages the treatment
6204 of a group of patients and bears the downside risk according to the terms of an alternate payment
6205 contract.

6206 “Risk certificate”, a certificate of solvency issued by the division of insurance.

6207 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
6208 business, which is not a health insurance plan, and in which the business is liable for the actual
6209 costs of the health care services provided by the plan and administrative costs.

6210 “Title XIX,” Title XIX of the Social Security Act, 42 USC 1396 et seq., or any successor
6211 statute enacted for the same purposes as Title XIX.

6212 Section 2. Except as hereinafter provided, a risk-bearing provider organization shall not
6213 be subject to chapters 175, 176A, 176B, 176C, 176E, 176F, 176G and 176J; provided, however,
6214 that a risk-bearing provider organization that enters into a contract with employers or individuals
6215 under which the provider organization would assume a significant portion of downside risk, as
6216 defined through division regulations, may be subject to the provisions of said chapters 175,
6217 176A, 176B, 176C, 176E, 176F, 176G and 176J for the purposes of such contracts.

6218 Section 3. (a) Each registered provider organization that enters into or renews an
6219 alternative payment contract with a carrier or public health care payer in which the provider
6220 organization accepts downside risk shall file an application for a risk certificate with the division;
6221 provided, however, that integrated care organizations or senior care organizations contracted
6222 under section 9D or 9E of chapter 118E which have undergone a financial solvency certification
6223 shall be deemed to be to have satisfied the risk certificate requirements for purposes of this
6224 chapter.

6225 (b) A risk-bearing provider organization may apply for a risk certificate waiver if it
6226 wishes to demonstrate that its alternative payment contracts do not contain significant downside
6227 risk. A risk-bearing provider organization may be deemed to be in compliance with the
6228 division's standards if the division determines that the provider organization's alternative
6229 payment contracts do not contain significant downside risk. The division shall forward such
6230 waiver in writing to the commission and the center.

6231 (c) The applicant for a risk certificate shall file such information as the commissioner
6232 shall by regulation require, in a form approved by the commissioner. A risk-bearing provider
6233 organization shall make an annual filing to renew its risk certificate. Such information shall
6234 include, but not be limited to:

6235 (1) the filing materials submitted to be registered as a provider organization,
6236 pursuant to chapter 6D;

6237 (2) a list of all carriers and public health payers with which the provider
6238 organization has entered into alternative payment contracts with downside risk;

6239 (3) financial statements showing the risk-bearing provider organization's assets,
6240 liabilities, reserves and sources of working capital and other sources of financial support and
6241 projections of the results of operations for the succeeding 3 years;

6242 (4) a financial plan, including a statement indicating the anticipated timing for
6243 receipt of income from alternative payment contracts with downside risk versus the incurrence
6244 of expenses, a statement of the applicant's plan to establish and maintain sufficient reserves or
6245 other resources that will protect the risk-bearing provider organization from the potential losses
6246 from downside risk, copies of insurance or other agreements which protect the risk-bearing
6247 provider organization from potential losses from downside risk, and a detailed description of
6248 mechanisms to monitor the financial solvency of any provider organization subcontracting with
6249 the applicant that assumes downside risk in its alternative payment arrangement with the risk-
6250 bearing provider organization;

6251 (5) a utilization plan describing the methods by which the risk-bearing provider
6252 organization will monitor inpatient and outpatient utilization under the alternative payment
6253 contracts with downside risk;

6254 (6) an actuarial certification that, after examining the terms of all the risk-bearing
6255 provider organization's alternative payment contracts with downside risk that the alternate
6256 payment contracts are not expected to threaten the financial solvency of the risk-bearing provider
6257 organization; and

6258 (7) such other information as the division may specify through regulation.

6259 (d) There shall be a fee for such application or renewal, in an amount determined by the
6260 commissioner.

(e) A risk-bearing provider organization shall notify the commissioner of any material change to the information submitted in its initial or renewal application, in a form approved by the commissioner.

Section 4. (a) The commissioner may make an examination of the affairs of a risk-bearing provider organization regarding its alternate payment arrangements with downside risk when the commissioner deems prudent but, not less frequently than once every 3 years. The focus of the examination shall be to ensure that a risk-bearing provider organization is not subject to adverse conditions which in the commissioner's determination have at least a moderate potential to impact a risk-bearing entity's ability to meet its risk-bearing responsibilities under any alternative payment contracts. The examination shall be conducted according to the procedures set forth in subsection (6) of section 4 of chapter 175.

(b) The commissioner, a deputy or an examiner may conduct an on-site examination of each risk-bearing provider organization in the commonwealth to thoroughly inspect and examine its affairs and ascertain its financial condition in the context of its ability to fulfill its risk-bearing obligations.

(c) The charge for each such examination shall be determined annually according to the procedures set forth in subsection (6) of section 4 of chapter 175.

(d) The assets and liabilities of the risk-bearing provider organization shall be allowed and computed, in any report of an examination under this section, in accordance with generally accepted accounting principles or as the commissioner may otherwise deem appropriate.

(e) No later than 60 days following completion of the examination, the examiner in charge shall file with the commissioner a verified written report of examination under oath.

6283 Upon receipt of the verified report, the commissioner shall transmit the report to the risk-bearing
6284 provider organization examined together with a notice which shall afford the risk-bearing
6285 provider organization examined a reasonable opportunity of not more than 30 days to make a
6286 written submission or rebuttal with respect to any matters contained in the examination report.
6287 Within 30 days of the end of the period allowed for the receipt of written submissions or
6288 rebuttals, the commissioner shall consider and review the reports together with any written
6289 submissions or rebuttals and any relevant portions of the examiner's work papers and enter an
6290 order:

6291 (i) adopting the examination report as filed with modifications or corrections and,
6292 if the examination report reveals that the risk-bearing provider organization is operating in
6293 violation of this section or any regulation or prior order of the commissioner, the commissioner
6294 may order the risk-bearing provider organization to take any action the commissioner considered
6295 necessary and appropriate to cure such violation;

6296 (ii) rejecting the examination report with directions to examiners to reopen the
6297 examination for the purposes of obtaining additional data, documentation or information and re-
6298 filing pursuant to the above provisions; or

6299 (iii) calling for an investigatory hearing with no less than 20 days notice to the
6300 risk-bearing provider organization for purposes of obtaining additional documentation, data,
6301 information and testimony.

6302 (f) Notwithstanding any other General Law to the contrary, including clause Twenty-
6303 sixth of section 7 of chapter 4 and chapter 66, the records of any such audit, examination or other
6304 inspection and the information contained in the records, reports or books of any risk-bearing

6305 provider organization examined pursuant to this section shall be confidential and open only to
6306 the inspection of the commissioner, or the examiners and assistants. Access to such confidential
6307 material may be granted by the commissioner to law enforcement officials of the commonwealth
6308 or any other state or agency of the federal government at any time, so long as the agency or
6309 office receiving the information agrees in writing to hold such material confidential. Nothing
6310 herein shall be construed to prohibit the required production of such records, and information
6311 contained in the reports of such company or organization before any court of the commonwealth
6312 or any master or auditor appointed by any such court, in any criminal or civil proceeding,
6313 affecting such risk-bearing provider organization, its officers, partners, directors or employees.
6314 The final report of any such audit, examination or any other inspection by or on behalf of the
6315 division of insurance shall be a public record.

6316 Section 5. (a) If upon examination or at any other time the commissioner determines that
6317 the risk-bearing provider organization's existing or proposed alternative payment contracts with
6318 downside risk are likely to threaten the financial solvency of the risk-bearing provider
6319 organization, the commissioner shall provide notice to the risk-bearing provider organization.

6320 (b) The commissioner may suspend, cancel, non-renew or refuse to issue a risk-bearing
6321 provider organization's risk certificate upon a determination that the risk-bearing provider
6322 organization has not cured a threat to financial solvency, that the risk-bearing provider
6323 organization's application for a risk certificate is incomplete or contains or is based on fraudulent
6324 information, or that the risk-bearing provider organization has otherwise failed to comply with
6325 the requirements of this chapter. The commissioner shall notify the risk-bearing provider
6326 organization and advise, in writing, of the reason for any refusal to issue or non-renew a risk
6327 certificate under this chapter. A copy of the notice shall be forwarded to the commission and

6328 center. The applicant or certified risk-bearing provider organization may make written demand
6329 upon the commissioner within 30 days of receipt of such notification for a hearing before the
6330 commissioner to determine the reasonableness of the commissioner's action. The hearing shall
6331 be held pursuant to chapter 30A.

6332 (c) The commissioner shall not suspend or cancel a risk certificate unless the
6333 commissioner has first afforded the risk-bearing provider organization an opportunity for a
6334 hearing pursuant to chapter 30A.

6335 (d) Upon a ruling by the commissioner to suspend or cancel a risk-bearing provider
6336 organization's certification, a written notice shall be forwarded to the commission and the center.

6337 Section 6. (a) For purposes of this section, "health care provider" shall mean any
6338 physician, hospital or other person or entity furnishing health services that has contracted to
6339 provide services according to its agreements with a risk-bearing provider organization.

6340 (b) A health care provider or any representative of a health care provider shall not
6341 maintain any action against a patient to collect or attempt to collect any money owed to the
6342 health care provider by a risk-bearing provider organization.

6343 (c) A risk-bearing provider organization shall include provisions within its contracts with
6344 health care providers that conspicuously prohibit health care providers from collecting or
6345 attempting to collect money from a patient that is owed to the health care provider by a risk-
6346 bearing provider organization.

6347 Section 7. All information provided by risk-bearing provider organizations to the
6348 division under this chapter shall be made available to the center and the commission.

6349 Section 8. Nothing in this chapter shall exempt any person from any applicable
6350 provisions of chapter 111, 112 or 176T including, but not limited to, provisions relating to
6351 determination of need, licensure and regulation of hospitals and clinics and registration of health
6352 professionals.

6353 Section 9. The commissioner shall promulgate rules and regulations as are necessary to
6354 carry out the provisions of this chapter. In developing the rules and regulations, including risk-
6355 bearing standards, certification and reporting requirements, the commissioner shall consider
6356 other rules and regulations applicable to such organizations and shall consult with the center and
6357 the commission regarding standards concerning provider organizations which enter into
6358 alternative payment contracts.

6359 SECTION 218. Section 8A of chapter 180 of the General Laws, as appearing in the 2010
6360 Official Edition, is hereby amended by striking out, in lines 100 and 101, the words “division of
6361 health care finance and policy pursuant to chapter 118G” and inserting in place thereof the
6362 following words:- center for health information and analysis under chapter 12C.

6363 SECTION 219. Section 9 of chapter 209C of the General Laws is hereby amended by
6364 striking out, in lines 36 and 37, as so appearing, the words “the division of medical assistance or
6365 division of health care finance and policy” and inserting in place thereof the following words:-
6366 the office of Medicaid or the executive office of health and human services.

6367 SECTION 220. Section 60K of chapter 231 of the General Laws, as so appearing, is
6368 hereby amended by striking out, in line 14, the figure “4” and inserting in place thereof the
6369 following figure:- 2.

6370 SECTION 221. Said chapter 231 is hereby further amended by inserting after section
6371 60K the following section:-

6372 Section 60L. (a) Except as otherwise provided in this section, a person shall not
6373 commence an action against a provider of health care as defined in the seventh paragraph of
6374 section 60B unless the person has given the health care provider 182 days written notice before
6375 the action is commenced.

6376 (b) The notice of intent to file a claim required under subsection (a) shall be mailed to the
6377 last known professional business address or residential address of the health care provider who is
6378 the subject of the claim.

6379 (c) The 182-day notice period in subsection (a) shall be shortened to 90 days if:

6380 (1) the claimant has previously filed the 182-day notice required against another
6381 health care provider involved in the claim; or

6382 (2) the claimant has filed a complaint and commenced an action alleging medical
6383 malpractice against any health care provider involved in the claim.

6384 (d) The 182 day notice of intent required in subsection (a) shall not be required if the
6385 claimant did not identify and could not reasonably have identified a health care provider to
6386 which notice shall be sent as a potential party to the action before filing the complaint;

6387 (e) The notice given to a health care provider under this section shall contain, but shall
6388 not be limited to, a statement including:

6389 (1) the factual basis for the claim;

6390 (2) the applicable standard of care alleged by the claimant;

6391 (3) the manner in which it is claimed that the applicable standard of care was
6392 breached by the health care provider;

6393 (4) the alleged action that should have been taken to achieve compliance with the
6394 alleged standard of care;

6395 (5) the manner in which it is alleged the breach of the standard of care was the
6396 proximate cause of the injury claimed in the notice; and

6397 (6) the names of all health care providers that the claimant intends to notify under
6398 this section in relation to a claim.

6399 (f) Not later than 56 days after giving notice under this section, the claimant shall allow
6400 the health care provider receiving the notice access to all of the medical records related to the
6401 claim that are in the claimant's control and shall furnish a release for any medical records related
6402 to the claim that are not in the claimant's control, but of which the claimant has knowledge.
6403 This subsection shall not restrict a patient's right of access to the patient's medical records under
6404 any other law.

6405 (g) Within 150 days after receipt of notice under this section, the health care provider or
6406 authorized representative against whom the claim is made shall furnish to the claimant or the
6407 claimant's authorized representative a written response that contains a statement including the
6408 following:

6409 (1) the factual basis for the defense, if any, to the claim;

6410 (2) the standard of care that the health care provider claims to be applicable to the
6411 action;

6412 (3) the manner in which it is claimed by the health care provider that there was or
6413 was not compliance with the applicable standard of care; and

6414 (4) the manner in which the health care provider contends that the alleged
6415 negligence of the health care provider was or was not a proximate cause of the claimant's alleged
6416 injury or alleged damage.

6417 (h) If the claimant does not receive the written response required under subsection (g)
6418 within the required 150-day time period, the claimant may commence an action alleging medical
6419 malpractice upon the expiration of the 150-day time period. If a provider fails to respond within
6420 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other
6421 means then interest on any judgment against that provider shall accrue and be calculated from
6422 the date that the notice was filed rather than the date that the suit is filed. At any time before the
6423 expiration of the 150-day period, the claimant and the provider may agree to an extension of the
6424 150-day period.

6425 (i) If at any time during the applicable notice period under this section a health care
6426 provider receiving notice under this section informs the claimant in writing that the health care
6427 provider does not intend to settle the claim within the applicable notice period, the claimant may
6428 commence an action alleging medical malpractice against the health care provider, so long as the
6429 claim is not barred by the statutes of limitations or repose.

6430 (j) A lawsuit against a health care provider filed within 6 months of the statute of
6431 limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any
6432 claimant, shall be exempt from compliance with this section.

6433 (k) Nothing in this section shall prohibit the filing of suit at any time in order to seek
6434 court orders to preserve and permit inspection of tangible evidence.

6435 SECTION 222. Section 85K of said chapter 231, as appearing in the 2010 Official
6436 Edition, is hereby amended by inserting after the word “costs”, in line 8, the following words:- ;
6437 and provided further, that in the context of medical malpractice claims against a nonprofit
6438 organization providing health care, such cause of action shall not exceed the sum of \$100,000,
6439 exclusive of interest and costs.

6440 SECTION 223. Chapter 233 of the General Laws is hereby amended by inserting after
6441 section 79K the following section:-

6442 Section 79L. (a) As used in this section, the following words shall, unless the context
6443 clearly requires otherwise, have the following meanings:

6444 “Facility”, a hospital, clinic, or nursing home licensed under chapter 111, a psychiatric
6445 facility licensed under chapter 19 or a home health agency; provided, however, that “facility”
6446 shall also include any corporation, professional corporation, partnership, limited liability
6447 company, limited liability partnership, authority or other entity comprised of such facilities.

6448 “Health care provider”, any of the following health care professionals licensed under
6449 chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, dental
6450 hygienist, optometrist, nurse, nurse practitioner, physician assistant, chiropractor, psychologist,

6451 independent clinical social worker, speech-language pathologist, audiologist, marriage and
6452 family therapist or mental health counselor; provided, however, that “health care provider” shall
6453 also include any corporation, professional corporation, partnership, limited liability company,
6454 limited liability partnership, authority, or other entity comprised of such health care providers.

6455 “Unanticipated outcome”, the outcome of a medical treatment or procedure, whether or
6456 not resulting from an intentional act, that differs from an intended result of such medical
6457 treatment or procedure.

6458 (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly
6459 experiencing an unanticipated outcome of medical care, all statements, affirmations, gestures,
6460 activities or conduct expressing benevolence, regret, apology, sympathy, commiseration,
6461 condolence, compassion, mistake, error or a general sense of concern which are made by a health
6462 care provider, facility or an employee or agent of a health care provider or facility, to the patient,
6463 a relative of the patient or a representative of the patient and which relate to the unanticipated
6464 outcome shall be inadmissible as evidence in any judicial or administrative proceeding, unless
6465 the maker of the statement, or a defense expert witness, when questioned under oath during the
6466 litigation about facts and opinions regarding any mistakes or errors that occurred, makes a
6467 contradictory or inconsistent statement as to material facts or opinions, in which case the
6468 statements and opinions made about the mistake or error shall be admissible for all purposes. In
6469 situations where a patient suffers an unanticipated outcome with significant medical
6470 complication resulting from the provider’s mistake, the health care provider, facility or an
6471 employee or agent of a health care provider or facility shall fully inform the patient and, when
6472 appropriate, the patient's family, about said unanticipated outcome.

6473 SECTION 224. Clause (2) of subsection (b) of section 3 of chapter 258C of the General
6474 Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out subclause (A)
6475 and inserting in place thereof the following subclause:-

6476 (A) Expenses incurred for hospital services as the direct result of injury to the victim
6477 shall be compensable under this chapter; provided, however, that when claiming compensation
6478 for hospital expenses, the claimant shall demonstrate an out-of-pocket loss or a legal liability for
6479 payment of said expenses. No hospital expenses shall be paid if the expense is reimbursable by
6480 Medicaid or if the services are covered by chapter 118E. Every claim for compensation for
6481 hospital services shall include a certification by the hospital that the services are not
6482 reimbursable by Medicaid and that the services are not covered by chapter 118E. In no event
6483 shall the amounts awarded for hospital services exceed the rates for services established by the
6484 executive office of health and human services or a governmental unit designated by the executive
6485 office if rates have been established for such services.

6486 SECTION 225. Section 62 of chapter 177 of the acts of 2001 is hereby amended by
6487 inserting after the word “commission”, in line 2, the following words: - , the executive director
6488 of the commonwealth health insurance connector authority.

6489 SECTION 226. The first paragraph of section 271 of chapter 127 of the acts of 1999 is
6490 hereby amended by inserting after the word “affairs”, in line 3, the following words:- , the
6491 executive director of the commonwealth health insurance connector authority.

6492 SECTION 227. Said first paragraph of said section 271 of said chapter 127 is hereby
6493 further amended by striking out clause (i) and inserting in place thereof the following words:- (i)
6494 enrollees in Commonwealth Care under chapter 176Q of the General Laws.

6495 SECTION 228. Section 16 of chapter 257 of the acts of 2008, as amended by section 27
6496 of chapter 9 of the acts of 2011, is hereby further amended by striking out the words “section 7
6497 of chapter 118G” and inserting in place thereof the following words:- section 13D of chapter
6498 118E.

6499 SECTION 229. Section 17 of said chapter 257, as most recently amended by section 28
6500 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words “7 of chapter
6501 118G” and inserting in place thereof the following words:- 13D of chapter 118E.

6502 SECTION 230. Section 18 of said chapter 257, as amended by section 29 of said chapter
6503 9, is hereby further amended by striking out the words “section 7 of chapter 118G” and inserting
6504 in place thereof the following words:- “section 13D of chapter 118E.

6505 SECTION 231. Section 15 of chapter 305 of the acts of 2008 is hereby repealed.

6506 SECTION 232. Section 31 of chapter 288 of the acts of 2010 is hereby repealed.

6507 SECTION 233. Section 54 of said chapter 288 is hereby repealed.

6508 SECTION 234. Said chapter 288 is hereby further amended by striking out section 66
6509 and inserting in place thereof the following section:—

6510 Section 66. For small group base rate factors applied under section 3 of chapter 176J of
6511 the General Laws between October 1, 2010 and July 1, 2015, a carrier shall limit the effect of the
6512 application of any single or combination of rate adjustment factors identified in clauses (2) to (6),
6513 inclusive, of subsection (a) of said chapter 3 of said chapter 176J that are used in the calculation
6514 of an individual’s or small group’s premium so that the final annual premium charged to an

6515 individual or small group does not increase by more than an amount established annually by the
6516 commissioner by regulation.

6517 SECTION 235. Section 70 of said chapter 288 is hereby repealed.

6518 SECTION 236. The first sentence of section 48 of chapter 9 of the acts of 2011 is hereby
6519 amended by striking out the words “7 of chapter 118G” and inserting in place thereof the
6520 following words:- 13D of chapter 118E.

6521 SECTION 237. Notwithstanding any general or special law to the contrary, no provision
6522 of this act shall be construed to impair or in any way modify the authority of the executive office
6523 of health and human services to act, pursuant to section 16 of chapter 6A of the General Laws, as
6524 the single state agency authorized to supervise and administer the state programs under titles
6525 XIX and XXI of the Social Security Act.

6526 SECTION 238. The commissioner of revenue, in consultation with the department of
6527 public health and the office of commonwealth performance, accountability and transparency,
6528 shall review the wellness program tax credit in section 6N of chapter 62 of the General Laws and
6529 section 38FF of chapter 63 of the General Laws and report on whether this tax credit achieved
6530 the desired outcome and stated public policy purpose of the tax credit and if the tax credit is the
6531 most cost effective means of achieving this public policy purpose and whether the tax credit
6532 should be subject to a recapture if certain conditions are not met. The commissioner shall file a
6533 report, together with any recommendations regarding whether there should be legislative changes
6534 to the tax credit or whether the goals of the tax credit can better be served through other means,
6535 to the governor and to the clerks of the house and senate who shall forward the same to the joint

6536 committee on revenue, the joint committee on health care financing, and the house and senate
6537 ways and means committees not later than January 1, 2017.

6538 SECTION 239. Notwithstanding any general or special law to the contrary, the
6539 commissioner of revenue, in consultation with the department of public health, shall authorize
6540 annually an amount not to exceed \$15,000,000 for the wellness program tax credit in section 6N
6541 of chapter 62 of the General Laws together with chapter 38FF of chapter 63 of the General Laws.

6542 SECTION 240. (a) The health information technology council, established in section 2
6543 of chapter 118I of the General laws, shall conduct an evaluation of the effectiveness of its
6544 expenditures under section 10 of said chapter 118I, and the Massachusetts e-health institute shall
6545 conduct an evaluation of the effectiveness of expenditures authorized under section 6D of
6546 chapter 40J of the General Laws and each shall submit a report thereon.

6547 (b) The reports by the council and the institute shall include an analysis of all relevant
6548 data so as to determine the effectiveness and return on investment of funding under section 6D of
6549 said chapter 40J and section 10 of chapter 118I. The reviews by the council and the institute shall
6550 each include specific findings and legislative recommendations including the following:-

6551 (1) to what extent their respective programs increased the adoption of
6552 interoperable electronic health records, including to what extent those programs increased the
6553 adoption of interoperable electronic health records for providers;

6554 (2) to what extent their respective programs reduced health care costs or the
6555 growth in health care cost trends on a provider-based net cost and health plan based premium
6556 basis, including an analysis of what entities benefitted from, or were disadvantaged by, any cost
6557 reductions and the specific impact of the funding mechanism;

6558 (3) to what extent their respective programs increased the number of health care
6559 providers in achieving and maintaining compliance with the standards for meaningful use,
6560 beyond stage 1, established by the United States Department of Health and Human Services;

6561 (4) to what extent their respective programs should be discontinued, amended or
6562 expanded and, if so, a timetable for implementation of the recommendations; and

6563 (5) to what extent additional public funding is needed for the implementation of
6564 their respective programs.

6565 (c) To the extent possible, the council and the institute shall obtain and use actual health
6566 plan data from the all-payer claims database as administered by the center for health information
6567 and analysis, but such data shall be confidential and shall not be a public record for any purpose.

6568 (d) The council and the institute shall report the results of their reviews and
6569 recommendations, if any, together with drafts of legislation necessary to carry out such
6570 recommendations by March 31, 2016. The report shall be provided to the chairs of the house
6571 and senate committees on ways and means and the chairs of the joint committee on health care
6572 financing and shall be posted on the council's and the institute's websites.

6573 SECTION 241. (a). Notwithstanding any special or general law to the contrary, the
6574 health policy commission shall establish a one-time surcharge assessment on all acute hospitals
6575 satisfying the requirements of subsection (b) to be deposited according to the requirements of
6576 subsection (f). The surcharge amount to be paid by each acute hospital shall equal the product
6577 of: (i) the surcharge percentage; and (ii) \$60,000,000. The commission shall calculate the
6578 surcharge percentage by dividing the operating surplus in fiscal year 2010 by the total operating
6579 surplus in fiscal year 2010 of all acute hospitals paying an assessment under this section. The

6580 commission shall determine the surcharge percentage for the assessment by December 31, 2012.
6581 In the determination of the surcharge percentage, the commission shall use the best data
6582 available as determined by the commission and may consider the effect on projected surcharge
6583 payments of any modified or waived enforcement pursuant to subsection (c). The commission
6584 shall incorporate all adjustments, including, but not limited to, updates or corrections or final
6585 settlement amounts, by prospective adjustment rather than by retrospective payments or
6586 assessments.

6587 (b) Only acute hospitals or acute hospital systems with more than \$1,000,000,000 in total
6588 net assets and less than 50 per cent of revenues from public payers shall be subject to the
6589 assessment. The commission may waive the assessment for certain acute hospitals, if the
6590 commission reasonably determines the hospital or hospital system lacks access to resources
6591 available to pay the assessment. The commission shall make a determination for waiver based
6592 on the following factors: (A) cash and investments on hand; (B) total revenues; (C) total cash and
6593 investments; (D) total reserves; (E) total profits, margins or surplus; (F) earnings before interest,
6594 depreciation and amortization; (G) administrative expense ratio; and (H) the compensation of
6595 executive managers and board members.

6596 (c) The commission may provide assessment mitigation up to 66 per cent of the surcharge
6597 assessment if an assessable provider meets either of the following:

6598 (1) any acute hospital or acute hospital system that receives more than 25 per cent
6599 of its reimbursements from Title XIX of the Social Security Act; or

6600 (2) any acute hospital or acute hospital system whose net assets do not exceed
6601 \$1,250,000,000.

6602 (d) Surcharge payors shall be assessed a surcharge to be paid to the commission in
6603 accordance with the provisions of subsection (e). The surcharge amount shall equal the product
6604 of: (i) the surcharge percentage; and (ii) \$165,000,000. The commission shall calculate the
6605 surcharge percentage by dividing the surcharge payor's payments for acute hospital services by
6606 the total payments for acute hospital services by all surcharge payors. The commission shall
6607 determine the surcharge percentage for the assessment by December 31, 2012. In the
6608 determination of the surcharge percentage, the commission shall use the best data available as
6609 determined by the commission and may consider the effect on projected surcharge payments of
6610 any modified or waived enforcement pursuant to subsection (c). The commission shall
6611 incorporate all adjustments, including, but not limited to, updates or corrections or final
6612 settlement amounts, by prospective adjustment rather than by retrospective payments or
6613 assessments.

6614 (e) Acute hospitals and surcharge payors shall pay the full amount of the surcharge
6615 amount as follows:

6616 (1) a single payment to be made no later than June 30, 2013; or

6617 (2) in 4 equal annual installments to be paid on or before June 30 of each year beginning
6618 on June 30, 2013.

6619 (f) The assessment shall be distributed as follows by the comptroller as such assessments
6620 are collected:

6621 (1) 60 per cent, for a 4-year a total of \$135,000,000 to the Distressed Hospital Trust
6622 Fund, established in section 2GGGG of chapter 29 of the General Laws; provided,

6623 however, that any reduced assessment under subsections (b) or (c) shall reduce this
6624 amount;

6625 (2) 26 and 2/3 per cent, for a 4-year total of \$60,000,000, to the Prevention and Wellness
6626 Trust Fund, established in section 2G of chapter 111 of the General Laws; and

6627 (3) 13 and 1/3 per cent, for a 4-year total of \$30,000,000 to the e-Health Institute Fund
6628 established in section 6E of chapter 40J.

6629 Prior to depositing the assessment in these funds, the comptroller shall deduct 5 per cent
6630 of each amount set forth in this subsection and transfer it to the Health Care Payment Reform
6631 Fund established in section 100 of chapter 194 of the acts of 2011 for the administration of the
6632 health policy commission.

6633 Deposits to the Prevention and Wellness Trust Fund and the e-Health Institute Fund shall
6634 not be reduced due to any waiver authorized by the commission under subsections (b) or (c).
6635 The total amount waived shall be reduced from the amount to be deposited in the Distressed
6636 Hospital Trust Fund.

6637 (g) The commission shall specify by regulation appropriate mechanisms that provide for
6638 determination and payment of an acute hospital, or a surcharge payor's liability, including
6639 requirements for data to be submitted by acute hospitals and surcharge payors.

6640 (h) A hospital's liability to the fund shall in the case of a transfer of ownership be
6641 assumed by the successor in interest to the hospital.

6642 (i) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
6643 assumed by the successor in interest to the surcharge payor.

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

(k) If an acute hospital or surcharge payor fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the commission, the commission shall provide written notice to the acute hospital or surcharge

6667 payor. If an acute hospital or surcharge payor fails to provide required information within 14
6668 days after the receipt of written notice, or falsifies the same, such hospital or payor shall be
6669 subject to a civil penalty of not more than \$5,000 for each day on which the violation occurs or
6670 continues, which penalty may be assessed in an action brought on behalf of the commonwealth
6671 in any court of competent jurisdiction. The attorney general shall bring any appropriate action,
6672 including injunctive relief, necessary for the enforcement of this chapter.

6673 (l) Acute hospitals shall not seek an increase in rates to pay for this assessment.

6674 (m) Surcharge payors shall not seek an increase in premiums to pay for this assessment.

6675 SECTION 242. Notwithstanding any general or special law to the contrary, to the extent
6676 permitted by federal law, every third-party administrator shall disclose to their self-insured or
6677 self-funded employer group health plan clients the contracted prices of services of in-network
6678 providers.

6679 SECTION 243. Any provider organization certified as an accountable care organization
6680 or a patient-centered medical home under chapter 6D of the General Laws and any risk-bearing
6681 provider organization shall have an interoperable electronic medical record system available for
6682 participants to coordinate care, share information and prescribe electronically by December 31,
6683 2016.

6684 SECTION 244. Notwithstanding any general or special law or rule or regulation to the
6685 contrary, the health care workforce center shall investigate the possibility of dedicating funds for
6686 joint appointments for clinicians with clinical agencies and universities. As part of the
6687 arrangement, clinicians pursuing doctoral education would receive tuition and fee reimbursement

6688 for maintaining a clinical position and teaching at the entry level of the academic program while
6689 pursuing their doctoral degree.

6690 SECTION 245. Notwithstanding any general or special law to the contrary, the executive
6691 office of health and human services shall seek from the secretary of the United States
6692 Department of Health and Human Services an exemption or waiver from the Medicare
6693 requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing facility be
6694 preceded by a 3-day hospital stay.

6695 SECTION 246. Notwithstanding any general or special law to the contrary, the office of
6696 Medicaid shall not terminate the coverage of any commonwealth care recipient, if: the office has
6697 requested documentation, including the eligibility review form; the recipient has provided such
6698 documentation on or before the date the office stated, in writing, that such documentation was to
6699 be submitted; and the office has acknowledged receipt of the documentation, until the office
6700 determines the eligibility for benefits based on the submitted information. The director of the
6701 office of Medicaid shall promulgate regulations to ensure the proper implementation of this
6702 section.

6703 SECTION 247. The secretary of administration and finance and the secretary of health
6704 and human services shall evaluate the feasibility of contracting for recycling durable medical
6705 equipment purchased and issued by the commonwealth through any and all of its medical
6706 assistance programs.

6707 Said evaluation shall include, but not be limited to, a request for qualifications or
6708 proposals from entities capable of developing, implementing and operating a system of recycling
6709 whereby an inventory of such equipment is developed and managed so as to maximize the

6710 quality of service delivery to equipment recipients and to minimize costs and losses attributable
6711 to waste, fraud or abuse.

6712 The secretary of administration and finance shall report the findings of the evaluation,
6713 together with cost estimates for the operation of a recycling program, estimates of the savings it
6714 would generate and legislative recommendation to the clerks of the house of representatives and
6715 the senate, one joint committee on health care financing, the house committee on ways and
6716 means and the senate committee on ways and means, not later than October 31, 2013.

6717 SECTION 248. Notwithstanding any general or special law to the contrary, the office of
6718 Medicaid and the department of unemployment assistance shall, in consultation with the
6719 executive office of health and human services, develop and implement a means by which the
6720 office of Medicaid may access information as to the status of or termination of unemployment
6721 benefits and the associated insurance coverage by the medical security plan, as administered by
6722 the executive office of labor and workforce development, for the purposes of determining
6723 eligibility for those individuals applying for benefits through health care insurance programs
6724 administered by the executive office of health and human services. The office and the
6725 department shall implement this system not later than February 1, 2013; provided, however, that
6726 if legislative action is required prior to implementation, recommendations for such action shall
6727 be filed with the clerks of the house of representatives and the senate and the joint committee on
6728 health care financing not later than January 1, 2013.

6729 SECTION 249. Notwithstanding any general or special law to the contrary, the division
6730 of insurance, in consultation with the board of registration in medicine, shall conduct a report on
6731 the potential for out-of-state physicians to practice telemedicine in the commonwealth. The

6732 report shall review the following: (i) licensure or authorization to practice medicine by an out-of-
6733 state physician; (ii) reimbursement of telemedicine services performed by out-of-state
6734 physicians; (iii) patient cost sharing responsibilities of telemedicine services performed by out-
6735 of-state physicians; (iv) any liability concerns associated with an out-of-state physician
6736 practicing medicine in the commonwealth, and the ability of patients to pursue medical
6737 malpractice claims; (v) the ability for out-of-state physicians to maintain an interoperable
6738 electronic health record; and (vi) the ability of out-of-state physicians to meet meaningful use
6739 standards associated with the commonwealth's health information exchange. To the extent
6740 possible, the division shall review and report on any national or regional licensure standards that
6741 exist or are being considered, and their implications on licensure of out-of-state physicians in the
6742 commonwealth. The report shall include recommendations for legislation to permit the use of
6743 out-of-state physicians for telemedicine. The report shall be submitted to clerks of the house of
6744 representatives and the senate, and the joint committees on health care financing and financial
6745 services by July 1, 2013.

6746 SECTION 250. Notwithstanding any special or general law to the contrary, the executive
6747 office of health and human services, in collaboration with the department of veterans' services
6748 and the office of Medicaid shall study methods to improve access to Department of Veterans'
6749 Affairs benefits for qualified veterans, survivors and dependents currently enrolled in the
6750 MassHealth program. The study shall include, but not be limited to: (i) identifying barriers to
6751 assisting these individuals in obtaining federal veteran health care benefits; and (ii) an
6752 examination of the feasibility, costs and benefits of utilizing the federal public assistance
6753 reporting information system (PARIS) to identify veterans and their dependents or surviving
6754 spouses who are enrolled in the MassHealth program. The study shall also examine the process

6755 and any projected information technology costs of exchanging information with the federal
6756 public assistance reporting information system. If the executive office of health and human
6757 services determines that the financial benefits outweigh the costs of utilizing the federal public
6758 assistance reporting information system, the executive office of health and human services shall
6759 be authorized to enter into any agreements and undertake such other measures as necessary to
6760 utilize such system to identify eligible veterans, dependents and survivors. The executive office
6761 may also, if it determines that the benefits outweigh the costs, enter into an agreement with the
6762 department of veterans' services to perform veterans outreach services to assist qualified
6763 veterans, survivors and dependents in obtaining benefits. Any such agreement shall contain
6764 performance standards that will allow the secretary of health and human services to measure the
6765 effectiveness of the program established by this section. The secretary of health and human
6766 services shall report the findings of this study and any actions taken pursuant this section to the
6767 joint committee on veterans and federal affairs, the joint committee on health care financing, and
6768 the house and senate committees on ways and means not later than April 1, 2013.

6769 SECTION 251. Notwithstanding any general or special law to the contrary, the office of
6770 the state auditor shall conduct a comprehensive review of the impact of this act on the health care
6771 payment and delivery system in the commonwealth and on health care consumers, the health
6772 care workforce and general public.

6773 The review shall include, but not be limited to, an investigation of:

6774 (1) The impact on health care costs, including the extent to which savings have
6775 reduced out-of-pocket costs to individuals and families, health insurance premium costs and
6776 health care costs borne by the commonwealth;

6777 (2) The impact on access to health care services and quality of care in different
6778 regions of the state and for different populations, particularly for children, the elderly, low-
6779 income individuals, individuals with disabilities and other vulnerable populations;

6780 (3) The impact on access and quality of care for specific services, particularly
6781 primary care, behavioral, substance use disorder and mental health services;

6782 (4) The impact on the health care workforce, including, but not limited to, health
6783 care worker recruitment and retention, health care worker shortages, training and education
6784 requirements and job satisfaction; and

6785 (5) The impact on public health, including, but not limited to, reducing the
6786 prevalence of preventable health conditions, improving employee wellness and reducing racial
6787 and ethnic disparities in health outcomes.

6788 The office of the state auditor shall, to the extent possible, obtain and use data from the
6789 center for health information and analysis, the health policy commission, and the department of
6790 public health to conduct its analysis; provided, however, that such data shall be confidential and
6791 shall not be a public record under clause twenty-sixth of section 7 of chapter 4 of the General
6792 Laws. The office of the state auditor may contract with an outside organization to conduct this
6793 review.

6794 The office of the state auditor shall report the results of such review and its
6795 recommendations, if any, together with drafts of legislation necessary to carry out such
6796 recommendations to the house and senate committees on ways and means and the joint
6797 committee on public health and post the results on the state auditor's website not later than
6798 March 31, 2017.

6799 SECTION 252. Nothing in this act shall be construed to preclude an individual from
6800 obtaining additional insurance or paying out of pocket for any medical service not covered by the
6801 individual's health plan.

6802 SECTION 253. Notwithstanding any general or special law to the contrary, the executive
6803 office of health and human services shall require Medicaid, any carrier or other entity which
6804 contracts with the office of Medicaid to pay for or arrange for the purchase of health care
6805 services, the commonwealth care health insurance program established under chapter 118H of
6806 the General Laws, any carrier or other entity which contracts with the commonwealth care health
6807 insurance program to pay for or arrange for the purchase of health care services, and any other
6808 state sponsored or state managed plan providing health care benefits to reimburse any licensed
6809 hospital facility operating in the commonwealth that has been designated as a critical access
6810 hospital under U.S.C. 1395i-4, in an amount equal to at least 101 per cent of allowable costs
6811 under each such program, as determined by utilizing the Medicare cost-based reimbursement
6812 methodology, for both inpatient and outpatient services.

6813 SECTION 254. Notwithstanding any general or special law, or rule or regulation to the
6814 contrary, the commissioner of insurance shall promulgate regulations requiring any carrier, as
6815 defined in section 1 of chapter 176O of the General Laws, and their contractors to comply with
6816 and implement the federal Mental Health Parity and Addiction Equity Act, section 511 of Public
6817 Law 110-343, and applicable state mental health parity laws, including section 22 of chapter
6818 32A of the General Laws, section 47B of chapter 175 of the General Laws, section 8A of chapter
6819 176A of the General Laws, section 4A of chapter 176B of the General Laws and sections 4, 4B
6820 and 4M of chapter 176G of the General Laws. The commissioner of insurance shall promulgate
6821 said regulations not later than January 1, 2013. The regulations shall be implemented as part of

6822 any provider contract and any carrier's health benefit plans delivered, issued, entered into,
6823 renewed, or amended on or after July 31, 2013.

6824 Starting on July 1, 2014, the commissioner of insurance shall require all carriers and their
6825 contractors, to submit an annual report to the division of insurance and to the attorney general,
6826 which shall be a public record, certifying and outlining how their health benefit plans comply
6827 with the federal Mental Health Parity and Addiction Equity Act, applicable state mental health
6828 parity laws, including said section 22 of said chapter 32A, said section 47B of chapter 175, said
6829 section 8A of chapter 176A, said section 4A of chapter 176B and said sections 4, 4B and 4M of
6830 chapter 176G, and this section. The division of insurance may, at the request of the attorney
6831 general, or in its own discretion, hold a public hearing relative to a carrier's or contractor's
6832 annual report.

6833 SECTION 255. Notwithstanding the provisions of any general or special law or
6834 regulation to the contrary, the provisions of section 16T of chapter 6A of the General Laws shall
6835 not apply to the review of an application for a determination of need that is filed with the
6836 department of public health under any applicable provision of said chapter 6A on or before
6837 December 31, 2013.

6838 SECTION 256. Notwithstanding any general or special law to the contrary, the health
6839 planning council shall submit a state health plan to the governor and the general court, as
6840 required by section 16T of chapter 6A of the General Laws, on or before January 1, 2014.

6841 SECTION 257. Notwithstanding subsection (d) of section 25C of chapter 111, health care
6842 providers that receive written notice from the department of public health, prior to December 31,

6843 2013, that they do not need a determination of need review for a project shall be exempt from the
6844 requirement to file a determination of need under said subsection for such project.

6845 SECTION 258. Notwithstanding any general or special law to the contrary, the board of
6846 registration in medicine, established under section 10 of chapter 13 of the General Laws, may
6847 promulgate regulations relative to the education and training of physicians in the early disclosure
6848 of adverse events including, but not limited to, continuing education requirements. Nothing in
6849 this section shall affect the total hours of continuing education required by the board, including
6850 the number of hours required relative to risk management.

6851 SECTION 259. Notwithstanding any general or special law to the contrary, the
6852 department of public health, in consultation with the division of insurance, shall examine and
6853 study best practices and successful models of private sector wellness and health management
6854 programs in order to create a model wellness guide for payers, employers and consumers. The
6855 department shall also issue a report that identifies those elements of said programs that should be
6856 promoted in support of the state's efforts to meet the health care cost growth benchmark
6857 established under section 9 of chapter 6D of the General Laws.

6858 The model guide shall provide the following information: (i) the importance of healthy
6859 lifestyles, disease prevention, care management and health promotion programs; (ii) financial
6860 and other incentives for brokers, payers and consumers to encourage health and wellness
6861 program offerings for consumers and to expand options for individuals who do not have access
6862 to these programs through their workplace; (iii) benefit designs that tie financial consequences to
6863 health care choices; (iv) use of technology to provide wellness information and services; (v) the
6864 benefits of participating in tobacco cessation programs and weight loss programs; (vi) the

6865 importance of chronic disease management, and complying with prescribed drug and follow up
6866 treatment regimens to reduce hospitalization for high-risk populations; (vii) a description of the
6867 discounts available to employees under the Affordable Care Act; and (viii) identifying qualitative
6868 and quantitative program measures to place real value on program results and track program
6869 effectiveness.

6870 In developing the report and model guide, the commissioner shall consult with health
6871 care stakeholders, including but not limited to: employers, including representatives of
6872 employers with more than 50 employees and representatives of employers with less than 50
6873 employees; providers and provider organizations; health carriers; public payers; researchers;
6874 community organizations; consumers; and other governmental entities. The report, along with
6875 any recommendations, shall be submitted to the clerks of the house of representatives and the
6876 senate, the joint committee on health care financing, the house and senate committees on ways
6877 and means and the secretary of health and human services by January 1, 2013. The
6878 recommendations shall assist in the development of strategies and programs supported by the
6879 Prevention and Wellness Trust Fund established under section 2G of chapter 111 of the General
6880 Laws.

6881 SECTION 260. Notwithstanding any general or special law to the contrary, the board of
6882 registration in nursing, established under section 13 of chapter 13 of the General Laws, may
6883 promulgate regulations relative to the education and training of advanced practice nurses
6884 authorized to practice under section 80B of chapter 112 of the General Laws, in the early
6885 disclosure of adverse events including, but not limited to, continuing education requirements.
6886 Nothing in this section shall affect the total hours of continuing education required by the board.

6887 SECTION 261. Notwithstanding and special or general law to the contrary, the office of
6888 Medicaid shall develop alternative payment methodologies including, but not limited to,
6889 bundled payments, global payments, shared savings and other innovative methods of paying for
6890 health care services. The office of Medicaid shall take actions necessary to amend its managed
6891 care organization and primary care clinician contracts as necessary to include such contracts in
6892 the innovation project. In developing the innovation project that employs alternative payment
6893 methodologies, the office of Medicaid shall consider payment and quality metric alignment with
6894 existing accountable care demonstrations implemented by the Centers for Medicare and
6895 Medicaid Services. The office of Medicaid shall consult with stakeholders including, but not
6896 limited to, the health care quality and cost commission, hospitals or hospital associations, carriers
6897 or carrier associations, consumer groups, physician or physician associations, and other health
6898 care providers, including safety net providers and high Medicaid and low-income public payer
6899 hospitals on developing alternative payment methodologies under this section. The office of
6900 Medicaid shall ensure that alternative payment methodologies: (i) support the state's efforts to
6901 meet the health care cost growth benchmark and to improve health, care delivery and cost-
6902 effectiveness; (ii) include incentives for high quality, coordinated care, including wellness
6903 services, primary care services and behavioral health services; (iii) include a risk adjustment
6904 element based on health status; (iv) to the extent possible, include a risk adjustment element that
6905 takes into account functional status, socioeconomic status or cultural factors; (v) preserve the use
6906 of intergovernmental transfer financing mechanisms by governmental acute public hospitals
6907 consistent with the Medical Assistance Trust Fund provisions in effect as of fiscal year 2012; and
6908 (vi) recognize the unique circumstances and reimbursement requirements of high Medicaid
6909 disproportionate share hospitals and other safety net providers with concentrated care in

6910 government programs. The office of Medicaid may also consider methodologies to account for
6911 the following costs: (1) medical education; (2) stand-by services and emergency services,
6912 including, but not limited to, trauma units and burn units; ; (3) services provided by
6913 disproportionate share hospitals or other providers serving underserved populations, including
6914 but not limited to, groups which suffer adverse health outcomes based on race, sex, ethnicity,
6915 disability, housing type, income level, primary language or educational attainment; (4) services
6916 provided to children; (5) research; (6) care coordination and community based services provided
6917 by allied health professionals, including, but not limited to, community health workers, legal
6918 advocates, medical interpreters, clinical prevention specialists, human services workers, social
6919 workers and licensed alcohol and drug counselors; (7) the greater integration of behavioral,
6920 substance use disorder and mental health; (8) the use and the continued advancement of new
6921 medical technologies, treatments, diagnostics or pharmacology products that offer substantial
6922 clinical improvements and represent a higher cost than the use of current therapies; (9) culturally
6923 and linguistically appropriate services; (10) interpreter services; (11) dedicated care management
6924 responsibilities and administrative responsibilities in alternative payment methodologies; and
6925 (12) costs associated with the services of a comprehensive cancer center, as defined in section
6926 8A of chapter 118E of the General Laws.

6927 In making the transition to alternative payment methodologies, the office of Medicaid
6928 shall achieve the following benchmarks, to the maximum extent feasible:

6929 (i) Not later than July 1, 2013, the office of Medicaid shall pay for health care
6930 utilizing alternative payment methodologies for no fewer than 25 per cent of its enrollees that are
6931 not also covered by other health insurance coverage, including Medicare and employer-
6932 sponsored or privately purchased insurance.

6933 (ii) Not later than July 1, 2014, the office of Medicaid shall pay for health care
6934 utilizing alternative payment methodologies for no fewer than 50 per cent of its enrollees that are
6935 not also covered by other health insurance coverage, including Medicare and employer-
6936 sponsored or privately purchased insurance.

6937 (iii) Not later than July 1, 2015, the office of Medicaid shall pay for health care
6938 utilizing alternative payment methodologies for no fewer than 80 per cent or the maximum
6939 percentage feasible of its enrollees that are not also covered by other health insurance coverage,
6940 including Medicare and employer-sponsored or privately purchased insurance.

6941 SECTION 262. Notwithstanding any special or general law to the contrary, in fiscal year
6942 2014, the secretary of health and human services shall provide an increase of 2 per cent to rates
6943 paid by the office of medicaid to acute care hospitals, non-acute care hospitals and to providers
6944 of primary care services that accept alternative payment methodologies from the office of
6945 Medicaid or any Medicaid managed care organization. The amount of the rate increase shall not
6946 exceed \$20,000,000 in the aggregate, and shall be in addition to any annual rate calculations,
6947 including updates for inflation, case-mix adjustments, base year updates and any other
6948 improvements to the rate methodology. The office of Medicaid shall only apply this rate increase
6949 to those hospitals and providers that have demonstrated to the satisfaction of MassHealth a
6950 significant transition to the use of alternative payment methodologies. The rate increase to
6951 qualifying hospitals and providers shall apply to all health care services provided to medical
6952 assistance recipients including outpatient, inpatient and behavioral health services, including, but
6953 not limited to, those under primary care clinician and mental health and substance abuse plans or
6954 through a Medicaid managed care organization. The office of Medicaid may establish by
6955 regulation what constitutes a significant use of alternative payment methodologies by a provider.

6956 The office of Medicaid shall not offset the rate increase by reducing Medicaid base rates to acute
6957 hospitals or providers of primary care. The office of Medicaid shall, to the greatest extent
6958 possible, seek federal financial participation to offset the cost of implementing this section

6959 SECTION 263. Notwithstanding any general or special law to the contrary, the health
6960 policy commission shall investigate and review methods of, and make recommendations relative
6961 to, increasing the use and adoption of flexible spending accounts, health reimbursement
6962 arrangements, health savings accounts and similar tax-favored health plans and developing and
6963 implementing incentives to increase the utilization of these types of plans. The health policy
6964 commission shall examine the feasibility of such accounts and plans for public payers and
6965 commercial insurers and the feasibility of a pilot program. The health policy commission shall
6966 submit a report of its findings and recommendations to the clerks of the house of representatives
6967 and the senate, the house and senate committees on ways and means and the joint committee on
6968 health care financing not later than April 1, 2013.

6969 SECTION 264. Notwithstanding any general or special law to the contrary, the
6970 department of revenue shall conduct a study to investigate the implementation of a pilot program
6971 to increase the adoption of health reimbursement arrangements, health savings accounts, flexible
6972 spending accounts and similar plans in the marketplace, including state employees and persons
6973 receiving subsidized health care. The study commission shall be chaired by the commissioner of
6974 revenue and shall include: 1 member representing consumers appointed by the governor; 1
6975 member who shall be appointed by the president of the senate; 1 member who shall be appointed
6976 by the minority leader of the senate; 1 member who shall be appointed by the speaker of the
6977 house of representatives; 1 member who shall be appointed by the minority leader of the house
6978 of representatives; the executive director of the group insurance commission, or a designee; 1

6979 member who shall represent the Massachusetts Bankers Association; 1 member who shall
6980 represent the Massachusetts Association of Health Underwriters; 1 member who shall represent
6981 the Massachusetts Association of Health Plans; 1 member who shall represent Blue Cross and
6982 Blue Shield of Massachusetts; and 1 member who shall represent the Associated Industries of
6983 Massachusetts. The commission shall file a report with recommendations, and any legislation
6984 that may be necessary for implementation, with the clerks of the house of representatives and
6985 senate, the senate and house committees on ways and means and the joint committee on health
6986 care financing not later than April 1, 2013.

6987 The scope of the study shall include, but not be limited to, identifying: (i) the barriers to
6988 full implementation of flexible spending accounts, health reimbursement accounts, health
6989 savings accounts and other tax-favored health plans; (ii) providing greater consumer choice; and
6990 (iii) incentives to increase utilization of flexible spending accounts, health reimbursement
6991 accounts, health savings accounts and other tax-favored health plans.

6992 SECTION 265. Notwithstanding any general or special law or rule or regulation to the
6993 contrary, the office of Medicaid shall promulgate regulations requiring any Medicaid health plan
6994 and managed care organization and their health plans and any behavioral health management
6995 firm and third party administrator under contract with a Medicaid managed care organization to
6996 comply with and implement the federal Mental Health Parity and Addiction Equity Act, section
6997 511 of Public Law 110-343, and applicable state mental health parity laws, including section 22
6998 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter
6999 176B and sections 4, 4B and 4M of chapter 176G of the General Laws. The office of Medicaid
7000 shall promulgate such regulations not later than January 1, 2013. The regulations shall be

7001 implemented as part of any provider contracts and any carrier's health benefit plans delivered,
7002 issued, entered into, renewed or amended on or after July 13, 2013.

7003 Starting on July 1, 2014, the office of Medicaid shall submit an annual report to the house
7004 and senate chairs of the joint committee on health care financing, the house and senate chairs of
7005 the joint committee on mental health and substance abuse, the clerk of the senate, the clerk of the
7006 house of representatives and the attorney general certifying and outlining how the health benefit
7007 plans under the office of Medicaid, and their contractors, comply with the federal Mental Health
7008 Parity and Addiction Equity Act, applicable state mental health parity laws, including said
7009 section 22 of said chapter 32A, said section 47B of said chapter 175, said section 8A of said
7010 chapter 176A, said section 4A of said chapter 176B, and said sections 4, 4B and 4M of said
7011 chapter 176G, and this section. The office of Medicaid may hold a hearing relative to a health
7012 benefit plan's or contractor's compliance with this section.

7013 SECTION 266. The office of Medicaid shall, within 6 months of the passage of this act,
7014 take any and all necessary actions to ensure that social security numbers are required on all
7015 medical benefits request forms to the extent permitted by federal law and that Social Security
7016 numbers are provided by all applicants who possess them. Further, the executive office of health
7017 and human services shall, within 6 months of the effective date of this act, ensure that the
7018 identity, age, residence and eligibility of all applicants are verified before payments, other than
7019 emergency bad debt payments, are made by the Health Safety Net Trust Fund;

7020 If for any reason the office of Medicaid or the executive office of health and human
7021 services determines that it is or will be unable to accomplish the foregoing within 6 months of
7022 the effective date of this act, said respective office shall submit a detailed report of the reasons

7023 for such inability to the clerks of the house of representatives and the senate within 6 months of
7024 the effective date of this act.

7025 SECTION 267. (a) Notwithstanding any general or special law to the contrary, the
7026 executive office of health and human services shall pursue all reasonable efforts to automatically
7027 renew eligible children and families into the MassHealth program, through the adoption of the
7028 express-lane eligibility option created under section 203 of the federal Children's Health
7029 Insurance Program Reauthorization Act of 2009, Public Law 111-3, as it pertains to renewals,
7030 and through the extension of that approach to all children and their eligible parents enrolled in
7031 medical assistance under chapter 118E of the General Laws. Specifically, the executive office
7032 shall seek federal authority under the section 1115 of the Social Security Act demonstration
7033 process or the state plan to automatically re-enroll all children and the eligible parents who are
7034 eligible for other state or federal assistance programs whose eligibility requirements are within
7035 the requirements for the applicable MassHealth program.

7036 (b) The executive office of health and human services shall provide families with renewal
7037 forms for all programs administered under said chapter 118E in which the fields have been pre-
7038 populated with the most current information known to the executive office. This subsection shall
7039 be effective not later than January 1, 2014.

7040 (c) There shall be a study committee to investigate the feasibility and cost of continuous
7041 MassHealth eligibility for children under the age of 19 to ensure that the same health care plans
7042 are offered through MassHealth and Commonwealth Care so that persons transitioning between
7043 different payers do not have to switch health plans. The committee shall consist of the following
7044 members: the director of the office of Medicaid, or a designee, who shall serve as chair; the

7045 secretary of health and human services, or a designee; the secretary of administration and
7046 finance, or a designee; the house chair of the joint committee on health care financing, or a
7047 designee; the senate chair of the joint committee on health care financing, or a designee; and a
7048 representative of health care consumers, to be appointed by the governor. The committee shall
7049 formulate relevant Medicaid state plan amendments, cost projections and information technology
7050 specifications necessary to implement continuous eligibility for children not later than June 30,
7051 2014.

7052 (d) Notwithstanding any general or special law to the contrary, the executive office of
7053 health and human services shall conduct an investigation of all federal and state assistance
7054 programs to determine which programs share eligibility requirements with MassHealth and
7055 which could feasibly share data with the MassHealth program for purposes of renewing eligible
7056 children and their eligible parents in MassHealth through the express-lane eligibility option
7057 created under said Children's Health Insurance Program Reauthorization Act of 2009, Public
7058 Law 111-3. The executive office shall submit a report on the results of such investigation by
7059 filing the same with the clerks of the house of representatives and the senate who shall forward
7060 the report to the house and senate committees on ways and means, the joint committee on health
7061 care financing and the joint committee on children and families and persons with disabilities not
7062 later than April 1, 2013."

7063 SECTION 268. Notwithstanding any general or special law to the contrary, to the extent
7064 that the office of Medicaid, the group insurance commission, the commonwealth health
7065 insurance connector authority and any other state funded insurance program determine that
7066 provider organizations organized as ACOs offer opportunities for cost-effective and high quality
7067 care, such state funded insurance programs shall prioritize provider organizations which have

7068 been certified by the board of the commission as ACOs, and designated as Model ACOs, for the
7069 delivery of publicly funded health services, provided that such ACOs, to the extent possible,
7070 assure the continuity of patient care.

7071 SECTION 269. Notwithstanding any special of general law to the contrary, for fiscal
7072 years 2013 through 2017 the center for health information and analysis and the health policy
7073 commission shall enter into an interagency agreement to transfer funds as necessary to support
7074 the transfer of functions from the center for health information and analysis to the health policy
7075 commission to supplement any funding needed in addition to those funds provided by the
7076 Healthcare Payment Reform Fund established in section 100 of chapter 194 of the acts of 2011.
7077 The executive director of the center for health information and analysis shall notify the
7078 comptroller of the amount to be transferred.

7079 SECTION 270. There shall be a special commission to review public payer
7080 reimbursement rates and payment systems for health care services and the impact of such rates
7081 and payment systems on health care providers and on health insurance premiums in the
7082 commonwealth. The commission shall consist of 13 members: 1 of whom shall be the secretary
7083 of health and human services or a designee, who shall serve as chair; 1 of whom shall be the
7084 director of the office of Medicaid; 1 of whom shall be the executive director of the center for
7085 health information and analysis; 1 of whom shall be appointed by the Massachusetts Hospital
7086 Association; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom
7087 shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed
7088 by the Home Care Alliance of Massachusetts; 1 of whom shall be appointed by the
7089 Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the
7090 Massachusetts Association for Behavioral Healthcare; 1 of whom shall represent a

7091 disproportionate share hospital; 1 of whom shall represent non-physician health care providers;
7092 and 2 of whom shall be appointed by the governor, 1 of whom shall be represent managed care
7093 organizations contracting with MassHealth and 1 of whom shall be an expert in medical payment
7094 methodologies from a foundation or academic institution.

7095 The commission shall examine whether public payer rates and rate methodologies
7096 provide fair compensation for health care services and promote high-quality, safe, effective,
7097 timely, efficient, culturally competent and patient-centered care. The commission's analysis shall
7098 include, but not be limited to, an examination of MassHealth rates and rate methodologies;
7099 current and projected federal financing, including Medicare rates; cost-shifting and the interplay
7100 between public payer reimbursement rates and health insurance premiums; possible funding
7101 sources for increased MassHealth rates including, but not limited to, utilizing increased federal
7102 Medicaid assistance percentage funds received under the Patient Protection and Affordable Care
7103 Act of 2010, Public Law 111-148, and section 1201 of the Health Care and Education
7104 Reconciliation Act of 2010, Public Law 111-152; and the degree to which public payer rates
7105 reflect the actual cost of care.

7106 To conduct its review and analysis, the commission may contract with an outside
7107 organization with expertise in the analysis of health care financing. The center for health
7108 information and analysis and the office of Medicaid shall provide the outside organization, to the
7109 extent possible, with any relevant data necessary for the evaluation; provided, however, that such
7110 data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7
7111 of chapter 4 of the General Laws.

7112 The commission shall file the results of its study, together with drafts of legislation, if
7113 any, necessary to carry out its recommendations, by filing the same with the clerks of the house
7114 of representatives and the senate who shall forward a copy of the study to the house and senate
7115 committees on ways and means and the joint committee on health care financing not later than
7116 April 1, 2013.

7117 SECTION 271. Notwithstanding any law or rule the contrary, for fiscal year 2014, in
7118 establishing Medicaid reimbursement rates for inpatient services provided by chronic disease
7119 rehabilitation hospitals located in the commonwealth that serve solely children and adolescents,
7120 the department of health and human services shall apply a multiplier of 1.5 times the hospital's
7121 inpatient per diem rate in fiscal year 2012. For fiscal year 2015 and fiscal year 2016, such rates
7122 of reimbursement shall not be lower than the rates in effect for the prior fiscal year.

7123 SECTION 272. Notwithstanding any general or special law to the contrary, the
7124 department of public health, in consultation with the Betsy Lehman center for patient safety and
7125 medical error reduction, established under section 16E of chapter 6A of the General Laws, shall
7126 create an independent task force consisting of no more than 11 members from a broad
7127 distribution of diverse perspectives to study and reduce the practice of defensive medicine and
7128 medical overutilization in the commonwealth, including but not limited to the overuse of
7129 imaging and screening technologies. The task force shall issue a report on the financial and non-
7130 financial impacts of defensive medicine and the impact of overutilization on patient safety. The
7131 task force shall file a report of its study, including its recommendations and drafts of any
7132 legislation, if necessary, by filing the same with the clerks of the senate and house of
7133 representatives who shall forward a copy of the report to the joint committee on public health
7134 and the joint committee on health care financing within 1 year of the effective date of this act.

SECTION 273. (a) There shall be a pharmaceutical cost containment commission established to study methods to reduce the cost of prescription drugs for both public and private payers. The commission shall consist of 16 members: 1 of whom shall be the senate chair of the joint committee on health care financing; 1 of whom shall be the house chair of the joint committee on health care financing; 1 of whom shall be the executive director of the group insurance commission or a designee; 1 of whom shall be the director of the division of insurance or a designee; 1 of whom shall be the director of the state office of pharmacy services or a designee; 1 of whom shall be the secretary of elder affairs or a designee; 1 of whom shall be the director of the Massachusetts Medicaid program or a designee; 3 of whom shall be appointed by the president of the senate, 1 of whom shall be appointed by the minority leader of the senate; 3 of whom shall be appointed by the speaker of the house of representatives, 1 of whom shall be appointed by the minority leader of the house of representatives; 1 of whom shall be a representative of the Massachusetts Association of Health Plans; 1 of whom shall be a representative of the Massachusetts Hospital Association; and 1 of whom shall be a representative of Health Care For All.

(b) The commission shall examine and report on the following: (i) the ability of the commonwealth to enter into bulk purchasing agreements, including agreements that would require the secretary of elder affairs, the executive director of the group insurance commission, the director of the state office of pharmacy services, the commissioners of the departments of public health, mental health and mental retardation, and any other state agencies involved in the purchase or distribution of prescription pharmaceuticals, to renegotiate current contracts; (ii) aggregate purchasing methodologies designed to lower prescription pharmaceutical costs for state and non-state providers; (iii) the ability of the commonwealth to operate as a single payer

7158 prescription pharmaceutical provider; and (iv) the feasibility of creating a program to provide all
7159 citizens access to prescription pharmaceuticals at prices negotiated by the commonwealth.

7160 (c) The commission shall report the results of its findings, together with any
7161 recommendations for legislation, programs and funding by filing the same with the clerks of the
7162 house of representatives and the senate who shall forward copies of the report to the house and
7163 senate committees on ways and means and the joint committee on health care financing not later
7164 than 12 months after the passage of this act.

7165 SECTION 274. There shall be a special task force to study and investigate issues related
7166 to the accuracy of medical diagnosis in the commonwealth. The task force shall investigate and
7167 report on: (i) the extent to which diagnoses in the commonwealth are accurate and reliable,
7168 including the extent to which different diagnoses and inaccurate diagnoses arise from the
7169 biological differences between the sexes; (ii) the underlying systematic causes of inaccurate
7170 diagnoses; (iii) an estimation of the financial cost to the state, insurers and employers of
7171 inaccurate diagnoses; (iv) the negative impact on patients caused by inaccurate diagnoses; and
7172 (v) recommendations to reduce or eliminate the impact of inaccurate diagnoses.

7173 The Massachusetts diagnostic accuracy task force shall be comprised of 9 members: 1 of
7174 whom shall be the secretary of health and human services, who shall chair the task force; 1 of
7175 whom shall be the commissioner of public health or a designee; 1 of whom shall be the chair of
7176 the board of registration in medicine or a designee; 1 of whom shall be the chair of the board of
7177 registration in nursing or a designee; and 5 members chosen by the governor, 1 of whom shall be
7178 a provider with experience in the area of diagnostic accuracy, 1 of whom shall be a representative
7179 of a Massachusetts health plan, 1 of whom shall be an employer with experience in

7180 implementing programs to address diagnostic inaccuracy, 1 whom shall represent an
7181 organization based in the commonwealth with experience creating and supporting the
7182 implementation of programs on diagnostic accuracy and value-based benefit design, and 1 of
7183 whom shall be a non-physician health care provider.

7184 SECTION 275. There shall be a special task force to examine behavioral, substance use
7185 disorder, and mental health treatment, service delivery, integration of behavioral health with
7186 primary care, and behavioral, substance use disorder and mental health reimbursement systems.
7187 The task force shall consist of 19 members: 1 whom shall be the commissioner of mental health,
7188 who shall serve as the chair; 1 of whom shall be a representative of the Massachusetts
7189 Psychiatric Society; 1 of whom shall be a representative of the Massachusetts Psychological
7190 Association; 1 of whom shall be a representative of the National Association of Social Workers-
7191 Massachusetts Chapter; 1 of whom shall be a representative of the Massachusetts Mental Health
7192 Counselors Association; 1 of whom shall be a representative of the Nurses United for
7193 Responsible Services; 1 of whom shall be a representative of the Massachusetts Association for
7194 Registered Nurses; 1 of whom shall be a representative of the Massachusetts Association of
7195 Behavioral Health Systems; 1 of whom shall be a representative of the Association for
7196 Behavioral Healthcare ; 1 of whom shall be a representative of the Mental Health Legal Advisors
7197 Committee; 1 of whom shall be a representative of the National Alliance for the Mentally Ill; 1
7198 of whom shall be a representative of the Children's Mental Health Campaign; 1 of whom shall
7199 be a representative of the Home Care Alliance of Massachusetts; 1 of whom shall be a
7200 representative of the National Empowerment Center; 1 of whom shall be a representative of the
7201 Massachusetts Organization for Addiction Recovery; 1 of whom shall be a representative of the
7202 Recovery Homes Collaborative; 1 of whom shall be a representative of the Massachusetts

7203 Hospital Association; and 3 members chosen by the Governor: 1 of whom shall be a provider
7204 with experience serving difficult to reach populations; 1 of whom shall be a provider with
7205 experience in serving dually diagnosed patients; and 1 of whom shall be a school nurse. In its
7206 examination, the task force shall review: (i) the most effective and appropriate approach to
7207 including behavioral, substance use and mental health disorder services in the array of services
7208 provided by provider organizations, including risk-bearing providers and patient-centered
7209 medical homes, including transition planning and maintaining continuity of care; (ii) how current
7210 prevailing reimbursement methods and covered behavioral, substance use and mental health
7211 benefits may need to be modified to achieve more cost effective, integrated and high quality
7212 behavioral, substance use and mental health outcomes; (iii) the extent to which and how payment
7213 for behavioral health services should be included under alternative payment methodologies,
7214 including how mental health parity and patient choice of providers and services could be
7215 achieved and the design and use of medical necessity criteria and protocols; (iv) how best to
7216 educate all providers to recognize behavioral, substance use and mental health conditions and
7217 make appropriate decisions regarding referral to behavioral health services; (v) how best to
7218 educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients
7219 with serious mental illness; and (vi) the unique privacy factors required for the integration of
7220 behavioral, substance use and mental health information into interoperable electronic health
7221 records. The task force shall submit its report, findings, and recommendations, along with any
7222 proposed legislation and regulatory changes, to the health policy commission, the clerks of the
7223 senate and house of representatives, and the house and senate chairs of the joint committee on
7224 mental health and substance abuse, and the house and senate chairs of the joint committee on
7225 health care financing not later than July 1, 2013.

SECTION 276. (a) There shall be a commission on prevention and wellness which shall evaluate the effectiveness of the program authorized under section 2G of chapter 111 of the General Laws. The commission shall consist of 20 members: 1 of whom shall be the commissioner of public health or a designee, who shall serve as the chair; 1 of whom shall be the executive director of the center for health information and analysis established in chapter 12C or a designee; 1 of whom shall be the secretary of health and human services or a designee; 2 of whom shall be the house and senate chairs of the joint committee on public health; 2 of whom shall be the house and senate chairs of the joint committee on health care financing; and 13 of whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field of public health economics, 1 of whom shall be a person with expertise in public health research, 1 of whom shall be a person with expertise in the field of health equity, 1 of whom shall be a person from a local board of health for a city or town with a population greater than 50,000, 1 of whom shall be a person of a board of health for a city or town with a population less than 50,000, 2 of whom shall be representatives of health insurance carriers, 1 of whom shall be a person from a consumer health organization, 1 of whom shall be a person from a hospital association, 1 of whom shall be a person from a statewide public health organization, 1 of whom shall be a representative of the interest of businesses, 1 of whom shall be a person representing frontline registered nurses and 1 of whom shall be a person from an association representing community health workers.

(b) The commission shall review the program authorized under said section 2G of said chapter 111 and shall issue a report. The report shall include an analysis of all relevant data to determine the effectiveness and return on investment of the program including, but not limited to, an analysis of: (i) the extent to which the program impacted the prevalence of preventable

7249 health conditions; (ii) the extent to which the program reduced health care costs or the growth in
7250 health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the
7251 reduction; (iv) the extent to which workplace-based wellness or health management programs
7252 were expanded, and whether those programs improved employee health, productivity and
7253 recidivism; (v) if employee health and productivity was improved or employee recidivism was
7254 reduced, the estimated statewide financial benefit to employers; (vi) recommendations for
7255 whether the program should be discontinued, amended or expanded, as well as a timetable for
7256 implementation of the recommendations; and (vii) recommendations for whether the funding
7257 mechanism for the Prevention and Wellness Trust Fund should be extended beyond 2016, or
7258 whether an alternative funding mechanism should be established

7259 (c) To conduct its evaluation, the commission shall contract with an outside organization
7260 with expertise in the analysis of health care financing. In conducting its evaluation, the outside
7261 organization shall, to the extent possible, obtain and use actual health plan data from the all-
7262 payer claims database as administered by the center for health information and analysis;
7263 provided, however, that such data shall be confidential and shall not be a public record under
7264 clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

7265 (d) The commission shall report the results of its investigation and study and its
7266 recommendation, if any, together with drafts of legislation necessary to carry out such
7267 recommendation to the house and senate committees on ways and means, the joint committee on
7268 public health and shall be posted on the department's website not later than June 30, 2015.

7269 SECTION 277. There shall be a special commission to examine the economic, social and
7270 educational value of graduate medical education in the commonwealth and to recommend a fair

7271 and sustainable model for the future funding of graduate medical education in the
7272 commonwealth.

7273 The commission shall consist of 13 members: 1 of whom shall be the secretary of health
7274 and human services or a designee, who shall serve as chair; 1 of whom shall be the secretary of
7275 administration and finance or a designee; 1 of whom shall be the secretary of labor and
7276 workforce development or a designee; 1 of whom shall be the commissioner of public health or a
7277 designee; and 9 whom shall be appointed by the secretary of health and human services, 1 of
7278 whom shall be a representative of the Massachusetts Hospital Association; 1 of whom shall be a
7279 representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the
7280 Massachusetts League of Community Health Centers; 4 of whom shall represent the
7281 commonwealth's medical schools; 1 of whom shall be a representative of the Conference of
7282 Boston Teaching Hospitals; and 1 of whom shall be a resident in training at a Massachusetts
7283 hospital.

7284 The commission shall investigate and report on the following issues:

7285 (1) the role of residents and medical faculty in the provision of health care in the
7286 commonwealth and throughout the United States;

7287 (2) the relationship of graduate medical education to the state's physician workforce and
7288 emerging models of delivery of care;

7289 (3) the current availability and adequacy of all sources of revenue to support graduate
7290 medical education and potential additional or alternate sources of funding for graduate medical
7291 education. Such review shall include the availability of federal graduate medical education
7292 funding to different types of sites where training takes place; and

7293 (4) approaches taken by other states to fund graduate medical education through,
7294 including, but not limited to: (a) Medicaid programs, (b) the establishment of medical education
7295 trust funds and (c) efforts to link payments to state policy goals, including:

7296 (i) increasing the number of high demand specialties or fellowships;

7297 (ii) enhancing retention of physicians practicing in the commonwealth;

7298 (iii) promoting practice in medically underserved areas of the state and reducing
7299 disparities in health care;

7300 (iv) increasing the primary care workforce;

7301 (v) increasing the behavioral health care workforce; and

7302 (vi) increasing racial and ethnic diversity within the physician workforce.

7303 The commission shall file a report of its findings and recommendations, together with
7304 drafts of legislation, if any, necessary to carry out its recommendations by filing the report with
7305 the clerks of the house of representatives and the senate who shall forward a copy of the report to
7306 the house and senate committees on ways and means and the joint committee on health care
7307 financing not later than April 1, 2013.

7308 SECTION 278. Notwithstanding any general or special law to the contrary, beginning on
7309 or before July 1, 2014, the group insurance commission, MassHealth and any other state funded
7310 insurance program shall, to the maximum extent feasible, implement alternative payment
7311 methodologies, as defined in section 1 of chapter 12C of the General Laws.

7312 SECTION 279. There shall be a special commission to review variation in prices among
7313 providers. The commission shall consist of 18 members: 1 of whom shall be the executive
7314 director of the center of health information and analysis or a designee, who shall serve as co-
7315 chair; 1 of whom shall be the executive director of the health policy commission, who shall serve
7316 as co-chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of
7317 whom shall be the executive director of the group insurance commission or a designee; 1 of
7318 whom shall be the secretary of health and human services or a designee; 1 of whom shall be the
7319 attorney general or a designee; 6 of whom shall be appointed by the governor, 1 of whom shall
7320 be a health economist, 1 of whom shall represent a high Medicaid and low-income public payer
7321 disproportionate share hospital, 1 of whom shall represent a hospital with 200 beds or less, 1 of
7322 whom shall represent a pharmaceutical manufacturer who shall be headquartered in the
7323 commonwealth, 1 of whom shall be a representative of an employer with less than 50 employees,
7324 and 1 of whom shall be a representative of an employer with more than 50 employees; 1 of
7325 whom shall be a representative of the Massachusetts Council of Community Hospitals; 1 of
7326 whom shall be a representative of the Massachusetts Association of Health Plans, Inc.; 1 of
7327 whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom
7328 shall be a representative of the Massachusetts Hospital Association, Inc.; 1 of whom shall be a
7329 representative of the Massachusetts Medical Society; 1 of whom shall be a representative of a
7330 medical device manufacturer who shall be headquartered in the commonwealth; and 1 of whom
7331 shall be a representative of the Conference of Boston Teaching Hospitals. In making
7332 appointments, the governor shall, to the maximum extent feasible, ensure that the commission
7333 represents a broad distribution of diverse perspectives.

7334 The commission shall conduct a rigorous, evidence based analysis to identify the
7335 acceptable and unacceptable factors contributing to price variation in physician, hospitals,
7336 diagnostic testing and ancillary services. The analysis shall include, but not be limited to, an
7337 examination of the following factors: quality, medical education, stand-by service capacity,
7338 emergency service capacity, special services provided by disproportionate share hospitals and
7339 other providers serving underserved or unique populations, market share of individual providers
7340 and affiliated providers, provider size, advertising, location, research, costs, care coordination,
7341 community-based services provided by allied health professionals and use of and continued
7342 advancement of medical technology and pharmacology. The analysis shall also include a
7343 comparison of price variation between providers in the commonwealth and providers in other
7344 states and a review of the feasibility of requiring insurers to separately contract with all provider
7345 locations for a multi-location provider, rather than contracting only with the individual provider
7346 locations and a review of contracting practices that require payers to pay the same or similar
7347 prices to all provider locations for a multi-location health care provider where geographic
7348 differences in the provider's site do not support charging the same or similar prices.

7349 After identifying the factors contributing to price variation, the commission shall
7350 recommend steps to reduce provider price variation and shall recommend the maximum
7351 reasonable adjustment to a commercial insurer's median rate for individual or groupings of
7352 services for each acceptable factor. To conduct its review and analysis, the commission may
7353 contract with an outside organization with expertise in the analysis of health care financing and
7354 provider payment methodologies. The center for health information and analysis shall provide
7355 the commission and any contracted outside organization, to the extent possible, relevant data

7356 necessary for the evaluation; provided, however, that such data shall be confidential and shall not
7357 be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

7358 The commission shall file the results of its study, together with drafts of legislation, if
7359 any, necessary to carry out its recommendations, by filing the study with the health policy
7360 commission and the clerks of the house of representatives and the senate who shall forward a
7361 copy of the study to the house and senate committees on ways and means and the joint
7362 committee on health care financing not later than January 1, 2014.

7363 SECTION 280. (a) Notwithstanding any general or special law to the contrary, the group
7364 insurance commission, the commonwealth health insurance connector authority, the office of
7365 Medicaid and any other state funded insurance program shall implement, to the maximum extent
7366 possible, alternative payment methodologies. The alternative payment methodologies shall be
7367 developed in consultation with all affected publically funded health plans, including, but not
7368 limited to, the Medicaid managed care organizations; provided, however, that any such agency or
7369 program shall be subject to any other implementation requirements provided for by law.

7370 (b) The executive office of health and human services shall seek a federal waiver of
7371 statutory provisions necessary to permit Medicare to participate in such alternative payment
7372 methodologies. Upon obtaining federal approval for Medicare participation, such participation
7373 shall be commenced and continued and the executive office shall seek extensions or additional
7374 approvals, as necessary. If federal approval cannot be obtained, or is revoked, then the
7375 requirements of this chapter, shall be conformed to federal standards for accountable care, shared
7376 savings, bundled payments, or alternative payment arrangements, to the greatest extent
7377 practicable.

(c) Private health plans shall to the maximum extent feasible reduce the use of fee-for-service payment mechanisms in order to promote high quality, efficient care delivery.

SECTION 281. (a) Notwithstanding any general or special law to the contrary, this section shall facilitate the orderly transfer of employees, proceedings, rules and regulations, property and legal obligations of the following functions of state government from the transferor agency to the transferee agency, defined as follows:

(1) the functions of the division of health care finance and policy, as the transferor agency, to the center for health information analysis and the health policy commission, as the transferee agencies; provided however, that this section shall not apply to the functions of the division of health care finance and policy that relate to the administration of the health safety net fund and that relate to the administration of the fair share assessment;

(2) the functions of the division of health care finance and policy related to the administration of the health safety net fund, as the transferor agency, to the office of Medicaid, as the transferee agency;

(3) the functions of the division of health care finance and policy related to the administration of the fair share assessment, as the transferor agency, to the commonwealth health insurance connector authority, as the transferee agency;

(3) the functions of the health care quality and cost council, as the transferor agency, to the health policy commission, as the transferee agency; provided, however, that this section shall not apply to the functions of the health care quality and cost council that relate to the administration of the consumer health information website;

7399 (4) the functions of the health care quality and cost council related to the
7400 consumer health information website, as the transferor agency, to the center for health
7401 information analysis, as the transferee agency;

7402 (4) the functions of the department of public health related to the statewide advisory
7403 committee on the standard quality measure set, as the transferor agency, to the center for health
7404 information analysis, as the transferee agency;

7405 (5) the functions of the department of public health related to the office of patient
7406 protection, as the transferor agency, to the health policy commission, as the transferee agency;

7407 (6) the functions of the Betsy Lehman center for patient safety and medical error
7408 reduction, as the transferor agency, to the center for health information analysis, as the transferee
7409 agency;

7410 (b) To the extent that employees of the transferor agency, including those who were
7411 appointed immediately before the effective date of this act and who hold permanent appointment
7412 in positions classified under chapter 31 of the General Laws or have tenure in their positions as
7413 provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold
7414 confidential positions, are transferred to the respective transferee agency, such transfers shall be
7415 effected without interruption of service within the meaning of said section 9A of said chapter 30,
7416 without impairment of seniority, retirement or other rights of the employee, and without
7417 reduction in compensation or salary grade, notwithstanding any change in title or duties resulting
7418 from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and
7419 benefits, and without change in union representation or certified collective bargaining unit as
7420 certified by the state division of labor relations or in local union representation or affiliation. Any

7421 collective bargaining agreement in effect immediately before the transfer date shall continue in
7422 effect and the terms and conditions of employment therein shall continue as if the employees had
7423 not been so transferred. The reorganization shall not impair the civil service status of any such
7424 reassigned employee who immediately before the effective date of this act either holds a
7425 permanent appointment in a position classified under said chapter 31 or has tenure in a position
7426 by reason of said section 9A of said chapter 30. Notwithstanding any other general or special law
7427 to the contrary, all such employees shall continue to retain their right to collectively bargain
7428 under chapter 150E of the General Laws and shall be considered employees for the purposes of
7429 said chapter 150E. Nothing in this section shall be construed to confer upon any employee any
7430 right not held immediately before the date of said transfer, or to prohibit any reduction of salary
7431 grade, transfer, reassignment, suspension, discharge, layoff or abolition of position not prohibited
7432 before such date.

7433 (c) All petitions, requests, investigations and other proceedings appropriately and duly
7434 brought before the transferor agency or duly begun by the transferor agency and pending before
7435 it before the effective date of this act, shall continue unabated and remain in force, but shall be
7436 assumed and completed by the transferee agency.

7437 (d) All orders, rules and regulations duly made and all approvals duly granted by the
7438 transferor agency, which are in force immediately before the effective date of this act, shall
7439 continue in force and shall thereafter be enforced, until superseded, revised, rescinded or
7440 canceled, in accordance with law, by the transferee agency.

7441 (e) All books, papers, records, documents, equipment, buildings, facilities, cash and other
7442 property, both personal and real, including all such property held in trust, which immediately

7443 before the effective date of this act are in the custody of the transferor agency shall be transferred
7444 to the transferee agency.

7445 (f) All duly existing contracts, leases and obligations of the transferor agency shall
7446 continue in effect but shall be assumed by the transferee agency. No existing right or remedy of
7447 any character shall be lost, impaired or affected by this act.

7448 (g) The comptroller shall be authorized to take any actions necessary to support the
7449 transfers outlined in this section. No existing right or remedy of any character shall be lost,
7450 impaired or affected by this act.

7451 SECTION 281A. The division of insurance shall develop uniform prior authorization
7452 forms for different health care services and benefits under subsections (c) and (d) of section 24 of
7453 chapter 176O of the General Laws not later than October 1, 2013.

7454 SECTION 281B. The division of insurance shall promulgate regulations to implement
7455 section 26 of chapter 176O of the General Laws not later than July 1, 2014.

7456 SECTION 283. Section 13 of chapter 6D of the General Laws shall take effect on
7457 January 1, 2013.

7458 SECTION 284. Section 6 of said chapter 6D shall take effect on July 1, 2016.

7459 SECTION 285. Section 228 of chapter 111 of the General Laws shall take effect on
7460 January 1, 2014.

7461 SECTION 286. Section 7 of chapter 118I of the General Laws shall take effect on
7462 January 1, 2017.

7463 SECTION 287. Section 6 of said chapter 118I shall take effect on January 1, 2017.

7464 SECTION 288. Section 108M of chapter 175 of the General Laws shall take effect on
7465 October 1, 2013.

7466 SECTION 289. Section 37 of chapter 176A of the General Laws shall take effect on
7467 October 1, 2013.

7468 SECTION 290. Section 24 of chapter 176B of the General Laws shall take effect on
7469 October 1, 2013.

7470 SECTION 291. Section 32 of chapter 176G of the General Laws shall take effect on
7471 October 1, 2013.

7472 SECTION 292. Section 17 of chapter 176J of the General Laws shall take effect on
7473 October 1, 2013.

7474 SECTION 293. Section 24 of chapter 176O of the General Laws shall take effect on
7475 October 1, 2013.

7476 SECTION 294. Section 25 of said chapter 176O shall take effect on January 1, 2014.

7477 SECTION 295. Section 36 shall take effect on October 1, 2013.

7478 SECTION 296. Section 37 shall take effect on October 1, 2014.

7479 SECTION 297. Section 41 and section 56 shall take effect on January 1, 2013.

7480 SECTION 298. Section 41A and 56A shall take effect on December 31, 2017.

7481 SECTION 299. Section 108 shall take effect as of January 1, 2015.

7482 SECTION 301. Sections 141 and 142 shall take effect on July 1, 2013.

7483 SECTION 302. Section 175 shall take effect on April 1, 2014.

7484 SECTION 303. Section 176 shall take effect on April 1, 2015.

7485 SECTION 304. Section 199 shall take effect on October 1, 2015.

7486 SECTION 305. Section 200 shall take effect on October 1, 2013.

7487 SECTION 306. Section 271 is hereby repealed.

7488 SECTION 307. Section 306 shall take effect on June 30, 2016.

7489 SECTION 308. Section 177 shall take effect on April 1, 2013.