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Acts 2008 **CHAPTER 305** AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE DELIVERY OF QUALITY HEALTH CARE.

Whereas, The deferred operation of this act would tend to defeat its purposes, which is to expand forthwith access to health care for residents of the commonwealth, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health.

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

SECTION 1. Subsection (d) of section 38C of chapter 3 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking out the third sentence and inserting in place thereof the following sentence:- The division shall enter into interagency agreements as necessary with the office of Medicaid, the group insurance commission, the department of public health, the division of insurance, the health care quality and cost council, and other state agencies holding utilization, cost or claims data relevant to the division's review under this section.

SECTION 2. Section 16J of chapter 6A, as so appearing, is hereby amended by inserting after the definition of "Physician Group Practice" the following definition:—

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

SECTION 3. Chapter 6A of the General Laws is hereby amended by striking out sections 16K, as so appearing, and 16L, as amended by section 1 of chapter 205 of the acts of 2007, and inserting in place thereof the following 2 sections:-

Section 16K. (a) There shall be established a health care quality and cost council within, but not subject to control of, the executive office of health and human services. The council shall promote public transparency of the quality and cost of health care in the commonwealth, and shall seek to improve health care quality, reduce racial and ethnic health disparities and contain health care costs by: (i) disseminating health care quality and cost data to consumers, health care providers and insurers via a consumer health information website pursuant to subsection (e) and (g); (ii) establishing quality improvement and cost containment goals pursuant to subsection (h); and (iii) establishing standard performance measures, quality performance benchmarks and statewide

health information technology adoption goals for health care providers and insurers pursuant to subsection (i).

(b) The council shall consist of 16 members and shall be comprised of: (i) 9 ex-officio members, including the secretary of health and human services, who shall serve as the chair, the secretary of administration and finance, the state auditor, the inspector general, the attorney general, the commissioner of insurance, the commissioner of health care finance and policy, the commissioner of public health, and the executive director of the group insurance commission, or their designees; and (ii) 7 representatives of nongovernmental organizations be appointed by the governor, including 1 representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 representative of the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1 representative of the Massachusetts Association of Health Underwriters, Inc., 1 representative of the Massachusetts Medicaid Policy Institute, Inc., 1 expert in health care policy from a foundation or academic institution, and 1 representative of a non-governmental purchaser of health insurance. At least 1 member of the council shall be a clinician licensed to practice in the commonwealth. Members of the council shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties which may include reimbursement for reasonable travel and living expenses while engaged in council business. Chapter 268A shall apply to all council members; provided, however, 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 further that such interest or involvement is disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided further, that no council member having such interest or involvement may participate in any decision relating to such organization.

(c) All meetings of the council shall be in compliance with chapter 30A, except that the council, through its by-laws, may provide for executive sessions of the council. No action of the council shall be taken in an executive session.

The council may, subject to chapter 30B and subject to appropriation, procure equipment, office space, goods and services.

The council shall receive staff assistance from the executive office of health and human services and may, subject to appropriation, appoint an executive director and employ such additional staff or consultants as it deems necessary. The executive office shall provide administrative support to the council as requested.

The council shall promulgate rules and regulations and may adopt by-laws necessary for the administration and enforcement of this section.

(d) The council shall disseminate the data it collects under this section to consumers, health care providers and insurers through: (i) a publicly-accessible consumer health information website; (ii)

reports on performance provided to health care providers; and (iii) any other analysis and reporting the council deems appropriate.

When collecting data, the council shall, to the extent possible, utilize existing public and private data sources and agency processes for data collection, analysis and technical assistance. The council may enter into an interagency service agreement with the division of health care finance and policy for data collection analysis and technical assistance.

The council may, subject to chapter 30B, contract with an independent health care organization for data collection, analysis or technical assistance related to its duties; provided, however, that the organization has a history of demonstrating the skill and expertise necessary to: (i) collect, analyze and aggregate data related to quality and cost across the health care system; (ii) identify quality improvement areas through data analysis; (iii) work with Medicare, MassHealth, and other insurers' data; (iv) collaborate in the design and implementation of quality improvement and clinical performance measures; (v) establish and maintain security measures necessary to maintain confidentiality and preserve the integrity of the data; and (vii) identify and, when necessary, develop appropriate measures of quality and cost for public reporting of quality and cost information.

Insurers and health care providers shall submit data to the council, to an independent health care organization with which the council has contracted, or to the division of health care finance and policy, as required by the council’s regulations. The council, through its rules and regulations, may determine what type of data may reasonably be required and the format in which it shall be provided.

The council may request that third-party administrators submit data to the council, to an independent health care organization with which the council has contracted, or to the division of health care finance and policy. The council, through its rules and regulations, may determine the format in which the data shall be provided. The council shall publicly post a list of third-party administrators that refuse to submit requested data.

If any insurer or health care provider fails to submit required data to the council on a timely basis, the council shall provide written notice to the insurer or health care provider. An insurer or health care provider that fails, without just cause, to provide the required information within 2 weeks following receipt of the written notice may be required to pay a penalty of $1,000 for each week of delay; provided, however, that the maximum annual penalty under this section shall be $50,000.

(e) The council shall, in consultation with the advisory committee established by section 16L, establish and maintain a consumer health information website. The website shall contain information comparing the quality and cost of health care services and may also contain general health care information as the council deems appropriate. The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices among health care providers. Information shall be presented in a format that is understandable to the average consumer. The council shall take appropriate action to publicize the availability of its website.

The council shall, in consultation with its advisory committee, 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 council, 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 council shall give priority to those measures that are already available in the public domain. As part of the reporting plan, the council shall determine for each service the comparative information to be included on the consumer health information website, including whether to: (i) list services separately or as part of a group of related services; or (ii) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately.

The council shall, after due consideration and public hearing, adopt or reject the reporting plan or any revisions. If the council rejects the reporting plan or any revisions, the council shall state its reasons for the rejection. The reporting plan and any revisions adopted by the council shall be promulgated by the council. The council shall submit the reporting plan and any periodic revisions 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 the clerks of the house and senate.

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

(f) The council, through its rules and regulations, shall provide access to data it collects pursuant to this section under conditions that: (i) protect patient privacy; (ii) prevent collusion or anti-competitive conduct; and (iii) prevent the release of data that could reasonably be expected to increase the cost of health care. The council may limit access to data based on its proposed use, the credentials of the requesting party, the type of data requested or other criteria required to make a determination regarding the appropriate release of the data. The council shall also limit the requesting party's use and release of any data to which that party has been given access by the council. The council shall provide the division of health care finance and policy with a database of health care claims data submitted pursuant to this section under an interagency service agreement for the purpose of conducting data analysis and preparing reports to assist in the formulation of health care policy and the provision and purchase of health care services.

Data collected by the council under this section shall not be a public record under clause twenty-sixth of section 7 of chapter 4 or under chapter 66, except as specifically otherwise provided by the council.

The council shall, through interagency service agreements, allow the use of its data by other state

agencies, including division of health care finance and policy, for review and evaluation of mandated health benefit proposals as required by section 38C of chapter 3.
(g) The council, in consultation with its advisory committee, shall disseminate to health care providers their individualized de-identified data, including comparisons with other health care providers on the quality, cost and other data to be published on the consumer health information website.
(h) The council, in consultation with its advisory committee, shall develop annual health care quality improvement and cost containment goals. The goals shall be designed to promote high-quality, safe, effective, timely, efficient, equitable and patient centered health care. The council shall also establish goals that are intended to reduce racial and ethnic health care disparities and in so doing shall seek to incorporate the recommendations of the health disparities council and the office of health equity. For each goal, the council shall: identify the steps needed to achieve the goal; estimate the cost of implementation; project the anticipated short-term or long-term financial savings achievable by the health care providers, insurers or the commonwealth: and estimate the expected improvements in the health status of health care consumers in the commonwealth. The council may recommend legislation or regulatory changes to achieve these goals.
(i) The council, in consultation with its advisory committee, relevant state agencies, and public and private health care organizations, shall develop and annually publish: (i) standard performance measures, including, common and consistent reporting of quality measures and common use of measures used for pay-for-performance reimbursement; (ii) quality performance benchmarks for health care providers and insurers that: (1) are clinically important, evidence-based, standardized and timely; (2) include both process and outcome measures; (3) encourage health care providers and insurers to improve health care quality; and (4) are developed based on the work of national organizations, including the National Quality Forum and the Hospitals Quality Alliance; and (iii) goals for statewide adoption of health information technology.
(k) The council shall conduct annual public hearings at which health care providers, insurers, relevant state agencies, and public and private health care organizations shall report their progress towards achieving the quality improvement and cost containment goals, adopting the standard performance measures and meeting the quality performance benchmarks. The council shall provide health care providers, insurers, state agencies and the general court with the following, at least 60 days prior to the public hearings: (i) recommended action required by each entity to achieve the specified quality and cost containment goals; and (ii) recommendations for adoption of each standard performance measure, quality performance benchmark and health information technology adoption goal established by the council.
(l) The council shall file a report, not less than annually, with the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate on its progress in achieving the goals of improving quality and containing or reducing health care costs data provided pursuant to chapter 111N. The report shall include, at a minimum, a review of the progress towards achieving the quality improvement and cost

containment goals, adoption of standard performance measures, meeting the quality performance benchmarks, and achieving the health information technology adoption goals.
The council shall provide its advisory committee with reasonable opportunity to review and comment on all reports before their public release.
Reports of the council shall be published on the consumer health information website.

Section 16L. (a) There shall be established an advisory committee to the health care quality and cost council, established by section 16K, to allow the broadest possible involvement of the health care industry and others concerned about health care quality and cost.
(b) The advisory committee shall consist of at least 29 members to be appointed by the governor, 1 of whom shall be a representative of the Massachusetts Medical Society, 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts AFL-CIO Council, Inc., 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc., 1 of whom shall be a representative of Health Care For All, Inc., 1 of whom shall be a representative of the Massachusetts Public Health Association, 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems, Inc., 1 of whom shall be a representative of the Massachusetts Extended Care Federation, Inc., 1 of whom shall be a representative of the Massachusetts Council of Human Service Providers, Inc., 1 of whom shall be a representative of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a representative of Associated Industries of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Business Roundtable, Inc., 1 of whom shall be a representative of the Massachusetts Taxpayers Foundation, 1 of whom shall be a representative of the Massachusetts chapter of the National Federation of Independent Business, 1 of whom shall be a representative of the Retailers Association of Massachusetts, 1 of whom shall be a representative of the Massachusetts Biotechnology Council, Inc., 1 of whom shall be a representative of the Blue Cross Blue Shield of Massachusetts Foundation, Inc., 1 of whom shall be a representative of the Massachusetts chapter of the American Association of Retired Persons, 1 of whom shall be a representative of the Massachusetts Coalition of Taft-Hartley Trust Funds, Inc., and additional members including, but not limited to, a representative of the mental health field, a representative of pediatric health care, a representative of primary health care, a representative of medical education, a representative of racial or ethnic minority groups concerned with health care, a representative of hospice care, a representative of the nursing profession and a representative of the pharmaceutical field. Members of the advisory committee shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation.
(c) The members of the advisory committee shall annually elect a chair, vice chair and secretary and may adopt by-laws governing the affairs of the advisory committee.

(d) The advisory committee shall have the following duties: (i) advise the council on the consumer health information website and health care provider and insurer reports; (ii) advise the council on the annual health care quality improvement and cost containment goals, transparency standards and quality performance benchmarks; and (iii) review and comment on all reports of the council before public release, including the annual reporting plan and any revisions and the annual report to the general court.
(e) A written record of all meetings of the committee shall be maintained by the secretary and a copy filed within 15 days after each meeting with the council.

SECTION 4. Chapter 40J of the General Laws is hereby amended by inserting after section 6C 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 electronic health records systems in all health care provider settings that are networked through a statewide health information exchange.
(b) There shall be established a health information technology council within the corporation. The council shall advise the institute on the dissemination of health information technology across commonwealth, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange.
The council shall consist of 9 members, as follows: 1 shall be the secretary of health and human services, who shall serve as the chair; 1 shall be the secretary of administration and finance, or a designee; 1 shall be the executive director of the health care quality and cost council; 1 shall be the director of the office of Medicaid; 5 shall be appointed by the governor, of whom at least 1 shall be an expert in health information technology, 1 shall be an expert in law and health policy, and 1 shall be an expert in health information privacy and security. The council may consult with such parties, public or private, as it deems desirable in exercising its duties under this section, including persons with expertise and experience the development and dissemination of electronic health records systems, and the implementation of electronic health record systems by small physician groups or ambulatory care providers, as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, physicians, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with expertise in health information

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

The members of the council shall be deemed to be directors for purposes of the fourth paragraph of section 3. 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 deemed to have violated section 4 of said chapter 268A because of his receipt of his usual and regular compensation from his employer during the time in which the member participates in the activities of the council.

(c) The institute, in consultation with the council, shall advance the dissemination of health information technology by: (i) facilitating the implementation and use of electronic health records systems by health care providers in order to improve health care delivery and coordination, reduce unwarranted treatment variation, eliminate wasteful paper-based processes, help facilitate chronic disease management initiatives and establish transparency; (ii) facilitating the creation and maintenance of a statewide interoperable electronic health records network that allows individual health care providers in all health care settings to exchange patient health information with other providers; and (iii) identifying and promoting an accelerated dissemination in the commonwealth of emerging health care technologies that have been developed and employed and that are expected to improve health care quality and lower health care costs, but that have not been widely implemented in the commonwealth.

(d) The institute director shall prepare and annually update a statewide electronic health records plan, and an annual update thereto. Each plan shall contain a budget for the application of funds from the E-Health Institute Fund for use in implementing each such plan. The institute director shall submit such plans and updates, and associated budgets, to the council for its approval. Each such plan and the associated budget shall be subject to approval of the board following action on it by the council.

Components of each such 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 such implementation plan shall address the development, implementation and dissemination of electronic health records systems among health care providers in the community or region, particularly providers, such as community health centers 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: (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 45 C.F.R. §§160, 162 and 164; (iv) meet standards for interoperability adopted by the institute with the approval of the council; (v) give patients the option of allowing only designated health care providers to disseminate their individually identifiable information; (vi) provide public health reporting capability as required under state law; and (vii) allow reporting of health information other than identifiable patient health information for purposes of such activities as the secretary of health and human services may from time to time consider necessary.

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

(f) Funding for the institute and council's activities shall be through the E-Health Institute Fund, established in section 6E. The institute, in consultation with the 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.

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

All grants shall be recommended by the institute director and subsequently approved by both the executive director and the council. The institute director shall work with implementation organizations to oversee the grant-making process as it relates to an implementing organization's responsibilities under its contract with the corporation. Each recipient of monies from this program

shall: (i) capture and report certain quality improvement data, as determined by the institute in consultation with the health care quality and cost council; (ii) implement the system fully, including all clinical features, not later than the second year of the grant; and (iii) make use of the system's full range of features.
(g) The council shall receive staff assistance from the corporation.
(h) The institute shall file an annual report, not later than January 30, with the joint committee on health care financing, the joint committee on economic development and emerging technologies, and the house and senate committees on ways and means concerning the activities of the council in general and, in particular, describing the progress to date in implementing a statewide electronic health records system and recommending such further legislative action as it deems appropriate.

Section 6E. There shall be established and set up on the books of the corporation the E-Health Institute Fund, hereinafter referred to as the fund, for the purpose of supporting the advancement of health information technology in the commonwealth, including, but not limited to, the full deployment of electronic health records. There shall be credited to the fund any appropriations, proceeds of any bonds or notes of the commonwealth issued for the purpose, or other monies authorized by the general court and designated thereto; 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 seek, to the greatest extent possible, private gifts, grants and donations to the fund. The corporation shall hold the fund in an account or accounts separate from other funds. The fund shall be administered by the executive director without further appropriation; provided, however, that any disbursement or expenditure from the fund for grants or for contracts with implementing organizations, as provided in section 6D, shall be approved by the health information technology council established under said section 6D. Amounts credited to the fund shall be available for reasonable expenditure by the corporation, subject to the approval of the health information technology council where such approval is required under this chapter, for such purposes as the corporation determines are necessary to support the dissemination and development of health information technology in the commonwealth, including, but not limited to, for the grant program established in said section 6D and for contracts with implementing organizations provided for in said section 6D.

Section 6F. Any plan approved by the board and every grantee and implementing organization that receives monies for the adoption of health information technology shall:
(1) establish a mechanism to allow patients to opt-in to the health information network and to opt-out at any time;
(2) maintain identifiable health information in physically and technologically secure environments by means including, but not limited to: prohibiting the storage or transfer of unencrypted and non-password protected identifiable health information on portable data storage devices; requiring data encryption, unique alpha-numerical identifiers and password protection; and other methods to

prevent unauthorized access to identifiable health information;
(3) provide individuals the option of, upon request, obtaining a list of individuals and entities that have accessed their identifiable health information; and
(4) develop and distribute to authorized users of the health information network and to prospective network participants, written guidelines addressing privacy, confidentiality and security of health information and inform individuals of what information about them is available, who may access their information, and the purposes for which their information may be accessed.

Section 6G. In the event of an unauthorized access to or disclosure of individually identifiable patient health information by or through the statewide health information network or by or through any technology grantees or implementing organizations funded in whole or in part from the E-Health Institute Fund established pursuant to section 6E, the operator of such network or grantee or contractor shall: (i) report the conditions of such unauthorized access or disclosure as required by the Massachusetts e-Health Institute; and (ii) provide notice, as defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days after such unauthorized access or disclosure, to any person whose patient health information may have been compromised as a result of such unauthorized access or disclosure, and shall report the conditions of such unauthorized access or disclosure.

SECTION 5. Chapter 111 of the General Laws is hereby amended by inserting after section 4M the following section:—

Section 4N. (a) The department shall, in cooperation with Commonwealth Medicine at the University of Massachusetts medical school, develop, implement and promote an evidence-based outreach and education program about the therapeutic and cost-effective utilization of prescription drugs for physicians, pharmacists and other health care professionals authorized to prescribe and dispense prescription drugs. In developing the program, the department shall consult with physicians, pharmacists, private insurers, hospitals, pharmacy benefit managers, the MassHealth drug utilization review board and the University of Massachusetts medical school.
(b) The program shall arrange for physicians, pharmacists and nurses under contract with the department to conduct face-to-face visits with prescribers, utilizing evidence-based materials and borrowing methods from behavioral science, educational theory and, where appropriate, pharmaceutical industry data and outreach techniques; provided, however, that to the extent possible, the program shall inform prescribers about drug marketing that is intended to circumvent competition from generic or other therapeutically-equivalent pharmaceutical alternatives or other evidence-based treatment options.
The program shall include outreach to: physicians and other health care practitioners who participate in MassHealth, the subsidized catastrophic prescription drug insurance program authorized in section 39 of chapter 19A or the commonwealth care health insurance program; other

publicly-funded, contracted or subsidized health care programs; academic medical centers; and other prescribers.
The department shall, to the extent possible, utilize or incorporate into its program other independent educational resources or models proven effective in promoting high quality, evidenced-based, cost-effective information regarding the effectiveness and safety of prescription drugs, including, but not limited to: (i) the Pennsylvania PACE/Harvard University Independent Drug Information Service; (ii) the Academic Detailing Program of the University of Vermont College of Medicine Area Health Education Centers; (iii) the Oregon Health and Science University Evidence-based Practice Center's Drug Effectiveness Review project; and (iv) the North Carolina evidence-based peer-to-peer education program outreach program.
(c) The department may establish and collect fees for subscriptions and contracts with private payers. The department may seek funding from nongovernmental health access foundations and undesignated drug litigation settlement funds associated with pharmaceutical marketing and pricing practices.

SECTION 6. Section 25B of said chapter 111, as appearing in the 2006 Official Edition, is hereby amended by striking out the definition of "Expenditure minimum with respect to substantial capital expenditures."

SECTION 7. Said section 25B of said chapter 111, as so appearing, is hereby further amended by inserting after the definition of "Department" the following definitions: -

"Expenditure minimum with respect to substantial capital expenditures", with respect to expenditures and acquisitions made by or for: (1) acute care hospitals and comprehensive cancer centers as defined in section 1 of chapter 118G, only, $7,500,000, except that expenditures for, or the acquisition of, major movable equipment not otherwise defined by the department as new technology or innovative services shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; and (2) health care facilities, other than acute care hospitals, and facilities subject to licensing under chapter 111B, with respect to: (a) expenditures for, or the acquisition of, medical, diagnostic or therapeutic equipment, $400,000; and (b) all other expenditures and acquisitions, $800,000; provided, however, that expenditures for, or the acquisition of, any replacement of medical, diagnostic or therapeutic equipment defined as new technology or innovative services for which a determination of need has issued or which was exempt from determination of need, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; provided further, that expenditures and acquisitions concerned solely with outpatient services other than ambulatory surgery, not otherwise defined as new technology or innovative services by the department, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum, unless the expenditures and acquisitions are at least $25,000,000, in which case a determination of

need shall be required. Notwithstanding the above limitations, acute care hospitals only may elect at their option to apply for determination of need for expenditures and acquisitions less than the expenditure minimum.

SECTION 8. Said chapter 111 is hereby further amended by inserting after section 25K the following 3 sections:—

Section 25L. (a) There shall be in the department a health care workforce center to improve access to health care services. The center, in consultation with the health care workforce advisory council established by section 25M and the commissioner of labor and workforce development, shall: (i) 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; (ii) monitor trends in access to primary care providers, nurse practitioners practicing as primary care providers, and other physician and nursing providers, through activities including: (1) review of existing data and collection of new data as needed to assess the capacity of the health care workforce to serve patients, including patient access and regional disparities in access to physicians or nurses and to examine physician and nursing satisfaction; (2) review existing laws, regulations, policies, contracting or reimbursement practices, and other factors that influence recruitment and retention of physicians and nurses; (3) making projections on the ability of the workforce to meet the needs of patients over time; (4) identifying strategies currently being employed to address workforce needs, shortages, recruitment and retention; (5) studying the capacity of public and private medical and nursing schools in the commonwealth to expand the supply of primary care physicians and nurse practitioners practicing as primary care providers; (iii) establish criteria to identify underserved areas in the commonwealth for administering the loan repayment program established under section 25N and for determining statewide target areas for health care provider placement based on the level of access; and (iv) address health care workforce shortages through the following activities, including: (1) coordinating state and federal loan repayment and incentive programs for health care providers; (2) providing assistance and support to communities, physician groups, community health centers and community hospitals in developing cost-effective and comprehensive recruitment initiatives; (3) maximizing all sources of public and private funds for recruitment initiatives; (4) designing pilot programs and make regulatory and legislative proposals to address workforce needs, shortages, recruitment and retention; and (5) making short-term and long-term programmatic and policy recommendations to improve workforce performance, address identified workforce shortages and recruit and retain physicians and nurses.

(c) The center shall maintain ongoing communication and coordination with the health care quality and cost council, established by section 16K of chapter 6A, and the health disparities council, established by section 16O of said chapter 6A.

(d) The center shall annually submit a report, not later than March 1, to the governor; the health care

quality and cost council established by section 16K of chapter 6A, the health disparities council established by section 16O of chapter 6A; and the general court, by filing the report with the clerk of the house of representatives, the clerk of the senate, the joint committee on labor and workforce development, the joint committee on health care financing, and the joint committee on public health. The report shall include: (i) data on patient access and regional disparities in access to physicians, by specialty and sub-specialty, and nurses; (ii) data on factors influencing recruitment and retention of physicians and nurses; (iii) short and long-term projections of physician and nurse supply and demand; (iv) strategies being employed by the council or other entities to address workforce needs, shortages, recruitment and retention; (v) recommendations for designing, implementing and improving programs or policies to address workforce needs, shortages, recruitment and retention; and (vi) proposals for statutory or regulatory changes to address workforce needs, shortages, recruitment and retention.

Section 25M. (a) There shall be a healthcare workforce advisory council within, but not subject to the control of, the health care workforce center established by section 25L. The council shall advise the center on the capacity of the healthcare workforce to provide timely, effective, culturally competent, quality physician and nursing services.
(b) The council shall consist of 16 members who shall be appointed by the governor: 1 of whom shall be a representative of the Massachusetts Extended Care Federation; 1 of whom shall be a physician with a primary care specialty designation who practices in a rural area; 1 of whom shall be a physician with a primary care specialty who practices in an urban area; 1 of whom shall be a physician with a medical subspecialty; 1 of whom shall be an advanced practice nurse, authorized under section 80B of said chapter 112, who practices in a rural area; 1 of whom shall be an advanced practice nurse, authorized under said section 80B of said chapter 112, who practices in an urban area; 1 of whom shall be a representative of the Massachusetts Organization of Nurse Executives; 1 of whom shall be a representative of the Massachusetts Academy of Family Physicians; 1 of whom shall be a representative of the Massachusetts Workforce Board Association; 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the Massachusetts Center for Nursing, Inc.; 1 of whom shall be a representative of the Massachusetts Nurses Association; 1 of whom shall be a representative of the Massachusetts Association of Registered Nurses; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall be a representative of Health Care For All, Inc. Members of the council shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties. Vacancies of unexpired terms shall be filled within 60 days by the appropriate appointing authority.
The members of the council shall annually elect a chair, vice chair and secretary and may adopt by-

laws governing the affairs of the council.
The council shall meet at least bimonthly, at other times as determined by its rules, and when requested by any 8 members.
(c) The council shall advise the center on: (i) trends in access to primary care and physician subspecialties and nursing services; (ii) the development and administration of the loan repayment program, established under section 25N, including criteria to identify underserved areas in the commonwealth; (iii) solutions to address identified health care workforces shortages; and (iv) the center's annual report to the general court.

Section 25N. (a) There shall be a health care workforce loan repayment program, administered by the health care workforce center established by section 25L. The program shall provide repayment assistance for medical school loans to participants who: (i) are graduates of medical or nursing schools; (ii) specialize in family health or medicine, internal medicine, pediatrics, psychiatry, or obstetrics/gynecology; (iii) demonstrate competency in health information technology, including use of electronic medical records, computerized physician order entry and e-prescribing; and (iv) meet other eligibility criteria, including service requirements, established by the board. Each recipient shall be required to enter into a contract with the commonwealth which shall obligate the recipient to perform a term of service of no less than 2 years in medically underserved areas as determined by the center.
(b) The center shall promulgate regulations for the administration and enforcement of this section which shall include penalties and repayment procedures if a participant fails to comply with the service contract.
The center shall, in consultation with the health care workforce advisory council and the public health council, establish criteria to identify medically underserved areas within the commonwealth. These criteria shall consist of quantifiable measures, which may include the availability of primary care medical services within reasonable traveling distance, poverty levels, and disparities in health care access or health outcomes.
(c) The center shall evaluate the program annually, including exit interviews of participants to determine their post-program service plans and to solicit program improvement recommendations.
(d) The center shall, not later than July 1, file an annual report with the governor, the clerk of the house of representatives, the clerk of the senate, the house committee on ways and means, the senate committee on ways and means, the joint committee on health care financing, the joint committee on mental health and substance abuse and the joint committee on public health. The report shall include annual data and historical trends of: (i) the number of applicants, the number accepted, and the number of participants by race, gender, medical or nursing specialty, medical or nursing school, residence prior to medical or nursing school, and where they plan to practice after program completion; (ii) the service placement locations and length of service commitments by participants; (iii) the number of participants who fail to fulfill the program requirements and the reason for the failures; (iv) the number of former participants who continue to serve in underserved

areas; and (v) program expenditures.

SECTION 9. Said chapter 111 is hereby further amended by inserting after section 51G the following section:-

Section 51H. (a) As used in this section the following words shall, unless the context clearly requires otherwise, have the following meanings:-
“Facility”, a hospital, institution for the care of unwed mothers or clinic providing ambulatory surgery as defined by section 25.
“Healthcare-associated infection”, a localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that: (i) occurs in a patient in a facility, (ii) was not present or incubating at the time of the admission during which the reaction occurs, and (iii) if occurring in a hospital, meets the criteria for a specific infection site as defined by the federal Centers for Disease Control and Prevention and its national health care safety network.
“Serious reportable event”, an event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria established by the department in regulations.
(b) A facility shall report data and information about healthcare-associated infections and serious reportable events. A serious reportable event shall be reported by a facility no later than 15 working days after its discovery. Reports shall be made in the manner and form established by the department in its regulations. The department may require facilities to register in and report to nationally recognized quality and safety organizations.
(c) The department shall, through interagency service agreements, transmit data collected under this section to the Betsy Lehman center for patient safety and medical error reduction and to the health care quality and cost council for publication on its consumer health information website. Any facility failing to comply with this section may: (i) be fined up to $1,000 per day per violation; (ii) have its license revoked or suspended by the department; or (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the department.
(d) The department shall promulgate regulations prohibiting a health care facility from charging or seeking reimbursement for services provided as a result of the occurrence of a serious reportable event. A health care facility shall not charge or seek reimbursement for a serious reportable event that the facility has determined, through a documented review process, and under regulations promulgated by the department, was (i) preventable; (ii) within its control; and (iii) unambiguously the result of a system failure based on the health care provider’s policies and procedures.

SECTION 10. Said chapter 111 is hereby further amended by inserting after section 51G the following section:-

Section 51H. (a) As used in this section the following words shall, unless the context clearly requires

otherwise, have the following meanings:
“Facility”, a hospital, institution for the care of unwed mothers or clinic providing ambulatory surgery as defined by section 25.
“Healthcare-associated infection”, a localized or systemic condition that results from an adverse reaction to the presence of an infectious agent or its toxins that: (i) occurs in a patient in a facility, (ii) was not present or incubating at the time of the admission during which the reaction occurs, and (iii) if occurring in a hospital, meets the criteria for a specific infection site as defined by the federal Centers for Disease Control and Prevention and its national health care safety network.
“Serious adverse drug event”, any preventable event that causes inappropriate medication use in a hospital or ambulatory surgical center that leads to harm to a patient, as further defined in regulations of the department.
“Serious reportable event”, an event that results in a serious adverse patient outcome that is clearly identifiable and measurable, reasonably preventable, and that meets any other criteria established by the department in regulations.
(b) A facility shall report data and information about healthcare-associated infections, serious reportable events, and serious adverse drug events. A serious reportable event shall be reported by a facility no later than 15 working days after its discovery. Reports shall be made in the manner and form established by the department in its regulations. The department may require facilities to register in and report to nationally recognized quality and safety organizations.
(c) The department, through interagency service agreements, shall transmit data collected under this section to the Betsy Lehman center for patient safety and medical error reduction and to the health care quality and cost council for publication on its consumer health information website. Any facility failing to comply with this section may: (i) be fined up to $1,000 per day per violation; (ii) have its license revoked or suspended by the department; or (iii) be fined up to $1,000 per day per violation and have its license revoked or suspended by the department.
(d) The department shall promulgate regulations prohibiting a health care facility from charging or seeking reimbursement for services provided as a result of the occurrence of a serious reportable event. A health care facility shall not charge or seek reimbursement for a serious reportable event that the facility has determined, through a documented review process, and under regulations promulgated by the department, was (i) preventable; (ii) within its control; and (iii) unambiguously the result of a system failure based on the health care provider’s policies and procedures.

SECTION 11. Said chapter 111 is hereby further amended by inserting after section 53D the following 3 sections:-

Section 53E. The department shall promulgate regulations for the establishment of a patient and family advisory council at each hospital in the commonwealth. The council shall advise the hospital on matters including, but not limited to, patient and provider relationships, institutional review boards, quality improvement initiatives and patient education on safety and quality matters.

Members of a council may act as reviewers of publicly reported quality information, members of task forces, members of awards committees for patient safety activities, members of advisory boards, participants on search committees and in the hiring of new staff, and may act as co-trainers for clinical and nonclinical staff, in-service programs, and health professional trainees or as participants in reward and recognition programs.

Section 53F. The department shall require acute care hospitals to have a suitable method for health care staff members, patients and families to request additional assistance directly from a specially-trained individual if the patient's condition appears to be deteriorating. The acute care hospital shall have an early recognition and response method most suitable for the hospital's needs and resources, such as a rapid response team. The method shall be available 24 hours per day.

Section 53G. Any entity that is certified or seeking certification as an ambulatory surgical center by the Centers for Medicare and Medicaid Services for participation in the Medicare program shall be a clinic for the purpose of licensure under section 51, and shall be deemed to be in compliance with the conditions for licensure as a clinic under said section 51 if it is accredited to provide ambulatory surgery services by the Accreditation Association for Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities or any other national accrediting body that the department determines provides reasonable assurances that such conditions are met. No original license shall be issued pursuant to said section 51 to establish any such ambulatory surgical clinic unless there is a determination by the department that there is a need for such a facility. For purposes of this section, "clinic" shall not include a clinic conducted by a hospital licensed under said section 51 or by the federal government or the commonwealth. The department shall promulgate regulations to implement this section.

SECTION 12. The first paragraph of section 70 of said chapter 111, as appearing in the 2006 Official Edition, is hereby amended by striking out the second and third sentences and inserting in place thereof the following 4 sentences:- These records may be handwritten, printed, typed or in electronic digital media or converted to electronic digital media as originally created by such hospital or clinic, by the photographic or microphotographic process, or any combination thereof. The hospital or clinic may destroy records only after the applicable retention period has elapsed and after notifying the department of public health, in accordance with its regulations, that the records will be destroyed. The department, through its regulations, shall establish an appropriate notification process. On the notice of privacy practices distributed to its patients, a hospital or clinic shall provide: (i) information concerning the provisions of this section and (ii) the hospital or clinic's records termination policy.

SECTION 13. Said section 70 of said chapter 111, as so appearing, is hereby further amended by

striking out, in line 66, the word “thirty” and inserting in place thereof the following figure:- 20.

SECTION 14. The General Laws are hereby amended by inserting after Chapter 111M the following chapter:-

CHAPTER 111N
PHARMACEUTICAL AND MEDICAL DEVICE MANUFACTURER CONDUCT

Section 1. As used in this chapter, the following words shall have the following meanings:-
“Department”, the department of public health.
“Health care practitioner”, a person who prescribes prescription drugs for any person and is licensed to provide health care, or a partnership or corporation comprised of such persons, or an officer, employee, agent or contractor of such person acting in the course and scope of his employment, agency or contract related to or in support of the provision of health care to individuals.
“Marketing code of conduct” practices and standards that govern the marketing and sale of prescription drugs or medical devices by a pharmaceutical or medical device manufacturing company to health care practitioners.
“Medical device”, an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent or other similar or related article, including any component, part or accessory, which is: (1) recognized in the official National Formulary or the United States Pharmacopeia or any supplement thereto; (2) intended for use in the diagnosis of disease or other conditions or in the cure, mitigation, treatment or prevention of disease, in persons or animals; or (3) intended to affect the structure or function of the body of a person or animal, and which does not achieve its primary intended purposes through chemical action within or on such body and which is not dependent upon being metabolized for the achievement of its primary intended purposes.
“Person”, a business, individual, corporation, union, association, firm, partnership, committee or other organization.
“Pharmaceutical or medical device manufacturer agent”, a pharmaceutical or medical device marketer or any other person who for compensation or reward does any act to promote, oppose or influence the prescribing of a particular prescription drug, medical device, or category of prescription drugs or medical devices; provided, however, that “pharmaceutical or medical device manufacturer agent” shall not include a licensed pharmacist, licensed physician or any other licensed health care practitioner with authority to prescribe prescription drugs who is acting within the ordinary scope of the practice for which he is licensed.
“Pharmaceutical or medical device manufacturing company”, any entity that participates in a commonwealth health care program and which is engaged in the production, preparation, propagation, compounding, conversion or processing of prescription drugs or medical devices, either directly or indirectly, by extraction from substances of natural origin, or independently by means of chemical synthesis or by a combination of extraction and chemical synthesis, or any entity

engaged in the packaging, repackaging, labeling, relabeling or distribution of prescription drugs; provided, however, that “pharmaceutical or medical device manufacturing company” shall not include a wholesale drug distributor licensed under section 36A of chapter 112 or a retail pharmacist registered under section 37 of said chapter 112.

“Pharmaceutical or medical device marketer”, a person who, while employed by or under contract with a pharmaceutical or medical device manufacturing company that participates in a commonwealth health care program, engages in detailing, promotional activities or other marketing of prescription drugs or medical devices in the commonwealth to any physician, hospital, nursing home, pharmacist, health benefits plan administrator, other health care practitioner or person authorized to prescribe, dispense or purchase prescription drugs; provided, however, that the “pharmaceutical or medical device marketer” shall not include a wholesale drug distributor licensed under section 36A of chapter 112, a representative of such a distributor who promotes or otherwise markets the services of the wholesale drug distributor in connection with a prescription drug or a retail pharmacist registered under section 37 of said chapter 112 if such person is not engaging in such practices under contract with a manufacturing company.

“Physician”, a person licensed to practice medicine by the board of registration in medicine under section 2 of chapter 112 who prescribes prescription drugs, or the physician’s employees or agents.

“Prescription drugs”, drugs upon which the manufacturer or distributor has placed or is required by federal law and regulations to place the following or a comparable warning: “Caution federal law prohibits dispensing without prescription”.

Section 2. Notwithstanding any general or special law to the contrary, the department shall adopt a standard marketing code of conduct for all pharmaceutical or medical device manufacturing companies that employ a person to sell or market prescription drugs or medical devices in the commonwealth. The marketing code of conduct shall be based on applicable legal standards and incorporate principles of health care including, without limitation, requirements that the activities of the pharmaceutical or medical device manufacturer agents be intended to benefit patients, enhance the practice of medicine and not interfere with the independent judgment of health care practitioners. In promulgating regulations for a marketing code of conduct, the department adopt regulations that shall be no less restrictive than the most recent version of the Code on Interactions with Healthcare Professionals developed by the Pharmaceutical Research and Manufacturers of America and the Code on Interactions with Healthcare Professionals developed by the Advanced Medical Technology Association.

The marketing code of conduct adopted by the department shall not allow:

(1) the provision of or payment for meals for health care practitioners that:

(a) are part of an entertainment or recreational event;

(b) are offered without an informational presentation made by pharmaceutical marketing agent or without the pharmaceutical marketing agent being present;

(c) are offered, consumed, or provided outside of the health care practitioner’s office or hospital

setting; or
(d) are provided to a healthcare practitioner's spouse or other guest;
(2) the provision or payment of entertainment or recreational items of any value, including, but not limited to, tickets to the theater or sporting events, sporting equipment, or leisure or vacation trips, to any health care practitioner who is not a salaried employee of the company;
(3) sponsorship or payment for continuing medical education, in this section referred to as CME, also known as independent medical education, that does not meet the Accreditation Council for Continuing Medical Education Standards For Commercial Support, or that provides payment directly to a health care practitioner;
(4) financial support for the costs of travel, lodging or other personal expenses of non-faculty healthcare practitioners attending any CME event, third-party scientific or educational conference, or professional meetings, either directly to the individuals participating in the event or indirectly to the event's sponsor, except in cases as determined by the department.
(5) funding to compensate for the time spent by health care practitioners participating in any CME event, third-party scientific or educational conferences, or professional meetings;
(6) the provision of or payment for meals directly at any CME event, third-party scientific or educational conferences, or professional meetings;
(7) payments in cash or cash equivalents to healthcare practitioners either directly or indirectly, except as compensation for bona fide services;
(8) any grants, scholarships, subsidies, support, consulting contracts, or educational or practice related items to a healthcare practitioner in exchange for prescribing prescription drugs or using medical devices or for a commitment to continue prescribing prescription drugs or using medical devices.
The marketing code of conduct adopted by the department shall allow:

(1) the provision, distribution, dissemination or receipt of peer reviewed academic, scientific or clinical information;
(2) the purchase of advertising in peer reviewed academic, scientific or clinical journals;
(3) prescription drugs provided to a health care practitioner solely and exclusively for use by the health care practitioner's patients;
(4) compensation for the substantial professional or consulting services of a health care practitioner in connection with a genuine research project or a clinical trial;
(5) payment for reasonable expenses necessary for technical training on the use of a medical device if that expense is part of the vendor's purchase contract for the device.
The department shall update the marketing code of conduct no less than every two years. The department may promulgate regulations or other guidelines as necessary to implement this section.

Section 3. No pharmaceutical or medical device manufacturer company or pharmaceutical or medical device manufacturer agent shall knowingly and willfully violate the marketing code of

conduct as adopted by the department.

Section 4. (a) A pharmaceutical or medical device manufacturing company that employs a person to sell or market a drug, medicine, or medical device in the commonwealth shall adopt and comply with the most recent marketing code of conduct as adopted by the department.
(b) A pharmaceutical or medical device manufacturing company that employs a person to sell or market prescription drugs or medical devices in the commonwealth shall adopt a training program to provide regular training to appropriate employees including, without limitation, all sales and marketing staff, on the marketing code of conduct.
(c) A pharmaceutical or medical device manufacturing company that employs a person to sell or market prescription drugs or medical devices in the commonwealth shall conduct annual audits to monitor compliance with the marketing code of conduct.
(d) A pharmaceutical or medical device manufacturing company that employs a person to sell or market a prescription drugs or medical devices in the commonwealth shall adopt policies and procedures for investigating instances of noncompliance with the marketing code of conduct and take corrective action in response to noncompliance and the reporting of instances of noncompliance to the appropriate state authorities.
(e) A pharmaceutical or medical device manufacturing company that employs a person to sell or market prescription drugs or medical devices in the commonwealth shall identify a compliance officer responsible for operating and monitoring the marketing code of conduct.

Section 5. A pharmaceutical or medical device manufacturing company that employs a person to sell or market prescription drugs or medical devices in the commonwealth shall annually submit to the department: (i) a description of its training program; (ii) a description of its investigation policies; (iii) the name, title, address, telephone number and electronic mail address of its compliance officer; and (iv) certification that it has conducted its annual audit and is in compliance with the marketing code of conduct.

Section 6. (1) By July 1 of each year, every pharmaceutical or medical device manufacturing company that employs a person to sell or market a drug, medicine, chemical, device or appliance in the commonwealth shall disclose to the department of public health the value, nature, purpose and particular recipient of any fee, payment, subsidy or other economic benefit with a value of at least $50, which the company provides, directly or through its agents, to any physician, hospital, nursing home, pharmacist, health benefit plan administrator, health care practitioner or other person in the commonwealth authorized to prescribe, dispense, or purchase prescription drugs or medical devices in the commonwealth. The disclosure shall be accompanied by the payment of a fee, to be determined by the department, to pay the costs of administering this section.
(2) The department of public health shall make all disclosed data publicly available and easily searchable on its website.

(3) The department of public health shall report to the attorney general any payment, entertainment, meals, travel, honorarium, subscription, advance, services or anything of value provided in violation of the market code of conduct as adopted by the department of public health.

Section 7. This chapter shall be enforced by the attorney general, the district attorney with jurisdiction over a violation or the department of public health. A person that violates this chapter shall be punished by a fine of not more than $5,000 for each transaction, occurrence or event that violates this chapter.

SECTION 15. The first paragraph of section 2 of chapter 112 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting the following after the second sentence of the first paragraph:- The board shall require, as a standard of eligibility for licensure, that applicants show a predetermined level of competency 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.

SECTION 16. Section 9E of said chapter 112, as so appearing, is hereby amended by striking out, in line 6, the word “two” and inserting in place thereof the following figure:- 4.

SECTION 17. Said chapter 112 is hereby further amended by inserting after section 39C the following section:-

Section 39E. Stores or pharmacies engaged in the drug business, as defined in section 37, shall inform the department of public health of any improper dispensing of prescription drugs that results in serious injury or death, as defined by the department in regulations, as soon as is reasonably and practically possible, but not later than 15 working days after discovery of the improper dispensing. The department of public health shall promulgate regulations for the administration and enforcement of this section.

SECTION 18. Chapter 118E of the General Laws is hereby amended by adding the following section:-

Section 55. (a) Subject to subsection (c), for the purposes of processing claims for health care services submitted by a health care provider and to provide uniformity and consistency in the reporting of patient diagnostic information, patient care service and procedure information as it relates to the submission and processing of health care claims, the executive office of health and human services and its subcontractors shall, without local customization, accept and recognize patient diagnostic information and patient care service and procedure information submitted

pursuant to, and consistent with, the current Health Insurance Portability and Accountability Act compliant code sets as adopted by the Centers for Medicare and Medicaid Services; the International Classification of Diseases; the American Medical Association's Current Procedural Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System. The executive office and its subcontractors shall adopt the aforementioned coding standards and guidelines, and all changes thereto, in their entirety, which shall be effective on the same date as the national implementation date established by the entity implementing the coding standards.
(b) Subject to subsection (c), the executive office and its subcontractors shall, without local customization, use the standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the federal Health Insurance Portability and Accountability Act. The executive office and its subcontractors shall, without local customization, adopt and routinely process all changes to such formats which shall be effective on the same date as the implementation date established by the entity implementing the formats.
(c) Except for the requirements for consistency and uniformity in coding patient diagnostic information and patient care service and procedure information, this section shall not modify or supersede the executive office’s or its subcontractor’s payment policy or utilization review policy. Nothing in this section shall preclude the executive office or a subcontractor thereof from adjudicating a claim pursuant to its billing guidelines, payment policies or provider contracts.
(d) The executive office and its subcontractors shall accept and recognize at least 85 per cent of all claims submitted by health care providers pursuant to this section.

SECTION 19. Section 55 of said chapter 118E, as inserted by section 19, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) The executive office and its subcontractors shall accept and recognize all claims submitted by health care providers pursuant to this section.

SECTION 20. Section 1 of chapter 118G of the General Laws is hereby amended by inserting after the definition of “Pediatric specialty unit”, as appearing in the 2006 Official Edition, the following definition:-

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

SECTION 21. Said section 1 of said chapter 118G, as so appearing, is hereby further amended by inserting after the definition of “Provider” the following definition:-

“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 the provisions of 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.

SECTION 22. Section 2 of said chapter 118G, as so appearing, is hereby amended by striking out the second paragraph, as most recently amended by section 38 of chapter 58 of the acts of 2006, and inserting in place thereof the following paragraph:-

The commissioner shall appoint and may remove such agents and subordinate officers as the commissioner may deem necessary and may establish such subdivisions within the division as he deems appropriate to fulfill the following duties: (i) to collect, analyze and disseminate health care data to assist in the formulation of health care policy and in the provision and purchase of health care services; (ii) to work with other state agencies including, but not limited to, the department of public health and the department of mental health, the health care quality and cost council, the division of medical assistance and the division of insurance to collect and publish data concerning the cost of health insurance in the commonwealth and the health status of individuals; (iii) to hold annual hearings concerning health care provider and payer costs and cost trends, and to provide an analysis of health care spending trends with recommendations for strategies to promote an efficient health delivery system; and (iv) to administer the health safety net office and trust fund established under sections 35 and 36.

SECTION 23. Section 6 of said chapter 118G, as so appearing, is hereby amended by striking out the third paragraph and inserting in place thereof the following 4 paragraphs:-

The division may promulgate regulations necessary to ensure the uniform reporting of information from private and public health care payers that enables the division to analyze: (i) changes over time in health insurance premium levels; (ii) changes in the benefit and cost-sharing design of plans offered by these payers; and (iii) changes in measures of plan cost and utilization; provided that this analysis shall facilitate comparison among plans and between public and private payers.
The division shall require the submission of data and other information from each private health care payer offering small or large group health plans including, without limitation: (i) 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; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan designs for each plan; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan; (v) information concerning the payer's current level of reserves and surpluses; and (vi) information on provider payment methods and levels.

The division shall require the submission of data and other information from public health care payers including, without limitation: (i) average premium rates for health insurance plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums; (ii) average annual per-member per-month payments for enrollees in MassHealth primary care clinician and fee for service programs; (iii) summaries of plan designs for each plan or program; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan or program; (v) where appropriate, information concerning the payer's current level of reserves and surpluses; and (vi) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid.

The division shall, before adopting regulations under this section, consult with other agencies of the commonwealth and the federal government, affected providers, and affected payers, as applicable, to ensure that the reporting requirements imposed under the regulations are not duplicative or excessive. If reporting requirements imposed by the division result in additional costs for the reporting providers, these costs may be included in any rates promulgated by the division for these providers. The division may specify categories of information which may be furnished under an assurance of confidentiality to the provider; provided that such assurance shall only be furnished if the information is not to be used for setting rates.

SECTION 24. Said chapter 118G is hereby further amended by inserting after section 6 the following section:—

Section 6½. (a) The division shall hold annual public hearings based on the information submitted under sections 6 and 6A concerning health care provider and private and public health care payer costs and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates. The attorney general may intervene in such hearings.

(b) The attorney general may review and analyze any information submitted to the division under section 6 and 6A. The attorney general may require that any provider or payer produce documents

and testimony under oath related to health care costs and cost trends or documents that the attorney general deems necessary to evaluate factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates. The attorney general shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose such information or documents to any person without the consent of the provider or payer that produced the information or documents except in a public hearing under this section, a rate hearing before the division of insurance, or in a case brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such confidential information and documents shall not be public records and shall be exempt from disclosure under section 10 of chapter 66.

(c) Hearings shall be held by the commissioner or a designee, or a hearings officer, if authorized by the commissioner. Public notice of any hearing shall be provided at least 60 days in advance.

(d) The division shall, 30 days before the date of any hearing, publish a preliminary report of its findings based on information provided under section 6. The division may contract with an outside organization with expertise in issues related to the topics of the hearings to produce this preliminary report. The division shall use this preliminary report as a basis for designing the format and content of the hearing.

(e) The division shall identify as witnesses for the public hearing a representative sample of providers and payers, 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 state; (iv) freestanding ambulatory surgical centers from at least 3 separate regions of the state; (v) community health centers from at least 3 separate regions of the state; (vi) the 5 private health care payers with the highest enrollments in the state; (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; and (x) any witness identified by the attorney general.

(f) Witnesses shall provide testimony under oath and subject to examination and cross examination by the division and the attorney general at the public hearing in a manner and form to be determined by the division, including without limitation: (i) in the case of providers, testimony concerning payment systems, payer mix, cost structures, administrative and labor costs, capital and technology costs, adequacy of public payer reimbursement levels, reserve levels, utilization trends, and cost-containment strategies, 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 (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, the payer's efforts to develop benefit design and payment policies that enhance product affordability and encourage efficient use of health resources and technology, efforts by the payer to increase consumer access to health care information, and efforts by the payer to promote the standardization of administrative practices, and any other matters as determined by the division.

(g) The division 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 division's analysis of information provided at the hearings by providers and insurers, data collected by the division under sections 6 and 6A of this chapter, and any other information the division considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the division. The division shall consult with the health care quality and cost council when developing any measures or criteria to be used in its analysis. The report shall be submitted to the chairs of the house and senate committees on ways and means, the chairs of the joint committee on health care financing and shall be published and available to the public no later than December 31st.

SECTION 25. Section 36 of chapter 123 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by adding the following 4 sentences:-

Each facility, subject to this chapter and section 19 of chapter 19, that provides mental health care and treatment shall maintain patient records, as defined in the first paragraph of section 70 of chapter 111, for at least 20 years after the closing of the record due to discharge, death or last date of service. A facility shall not destroy such records until after the retention period has elapsed and only upon notifying the department of public health that the records will be destroyed, provided that the department shall promulgate regulations further defining an appropriate notification process. On the notice of privacy practices distributed to its patients, each facility shall provide: (i) information concerning the provisions of this section; and (ii) the hospital or clinic's records termination policy.

SECTION 26. Chapter 176O of the General Laws is hereby amended by inserting after section 5 the following 2 sections:-

Section 5A. (a) Subject to subsection (c), for the purposes of processing claims for health care services submitted by a health care provider and to provide uniformity and consistency in the reporting of patient diagnostic information, patient care service and procedure information as it relates to the submission and processing of health care claims, a carrier and its subcontractors shall, without local customization, accept and recognize patient diagnostic information and patient care service and procedure information submitted pursuant to, and consistent with the current Health Insurance Portability and Accountability Act compliant code sets: the International

Classification of Diseases; the American Medical Association's Current Procedural Terminology codes, reporting guidelines and conventions; and the Centers for Medicare and Medicaid Services Healthcare Common Procedure Coding System. A carrier and its subcontractors shall adopt the aforementioned coding standards and guidelines, and all changes thereto, in their entirety, which shall be effective on the same date as the national implementation date established by the entity implementing the coding standards.

(b) Subject to subsection (c), a carrier and its subcontractors shall, without local customization, use the standardized claim formats for processing health care claims as adopted by the National Uniform Claim Committee and the National Uniform Billing Committee and implemented pursuant to the Health Insurance Portability and Accountability Act. A carrier and its subcontractors shall, without local customization, adopt and routinely process all changes to such formats which shall be effective on the same date as the implementation date established by the entity implementing the formats.

(c) Except for the requirements for consistency and uniformity in coding patient diagnostic information and patient care service and procedure information, this section shall not modify or supersede a carrier’s or its subcontractor’s payment policy, utilization review policy or benefits under a health benefit plan. Nothing in this section shall further preclude a carrier or a subcontractor thereof from adjudicating a claim pursuant to its billing guidelines, payment policies, provider contracts or health benefit plans.

(d) Carriers and subcontractors thereof shall accept and recognize at least 85 per cent of all claims submitted by health care providers pursuant to this section.

Section 5B. To ensure uniformity and consistency in the submission and processing of claims for health care services pursuant to section 5A, the bureau of managed care within the division of insurance, after consultation with a statewide advisory committee including, but not limited to, representatives of the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association, the Massachusetts Health Data Consortium, a representative of America's Health Insurance Plans, a representative of a MassHealth contracted managed care organization, the executive office of health and human services, the division of health care finance and policy, the health care quality and cost council, the house of representatives and the senate, shall adopt policies and procedures to enforce said section 5A. The policies and procedures shall include a system for reporting inconsistencies related to a carrier’s compliance with said section 5A. The bureau shall work jointly with the executive office of health and human services to resolve reports of noncompliance with the requirements of section 61 of chapter 118E. The bureau shall convene the advisory committee annually to review and discuss issues reported by health care providers pursuant to this section and to discuss further recommendations to improve the uniformity and consistency of the reporting of patient diagnostic information and patient care service and procedure information as it relates to the submission and

processing of health care claims.

SECTION 27. Section 5A of said chapter 176O, as appearing in section 23, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) Carriers and their subcontractors shall accept and recognize all claims submitted by health care providers pursuant to this section.

SECTION 28. The General Laws are hereby amended by inserting after chapter 176Q the following chapter:-

CHAPTER 176R
CONSUMER CHOICE OF NURSE PRACTITIONER SERVICES

Section 1. As used in this chapter, the following words shall have the following meanings unless the context clearly requires otherwise:
“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; an organization entering into a preferred provider arrangement under chapter 176I; a contributory group general or blanket insurance for persons in the service of the commonwealth under chapter 32A; a contributory group general or blanket insurance for persons in the service of counties, cities, towns and districts, and their dependents under chapter 32B; the medical assistance program administered by the division of medical assistance pursuant to chapter 118E and in accordance with Title XIX of the Social Security Act or any successor statute; and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.
“Commissioner”, the commissioner of insurance.
“Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.
“Nondiscriminatory basis”, a carrier shall be deemed to be providing coverage on a non-discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a nurse practitioner which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other participating providers.
“Nurse practitioner”, a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under section 80B of chapter 112 and regulations promulgated thereunder.
“Participating provider”, a provider who, under the terms and conditions of a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to an insured with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly

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

Section 2. The commissioner and the group insurance commission shall require that all carriers recognize nurse practitioners as participating providers subject to section 3 and shall include coverage on a nondiscriminatory basis to their insureds for care provided by nurse practitioners for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a nurse practitioner who is a participating provider and is practicing within the scope of his professional license to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.

Section 3. A participating provider nurse practitioner practicing within the scope of his license including all regulations requiring collaboration with a physician under section 80B of chapter 112, shall be considered qualified within the carrier’s definition of primary care provider to an insured.

Section 4. Notwithstanding any general or special law to the contrary, a carrier that requires the designation of a primary care provider shall provide its insured with an opportunity to select a participating provider nurse practitioner as a primary care provider or to change its primary care provider to a participating provider nurse practitioner at any time during their coverage period.

Section 5. Notwithstanding any general or special law to the contrary, a carrier shall ensure that all participating provider nurse practitioners are included on any publicly accessible list of participating providers for the carrier.

Section 6. A complaint for noncompliance against a carrier shall be filed with and investigated by the commissioner or the group insurance commission, whichever shall have regulatory authority over the carrier. The commissioner and the group insurance commission shall promulgate regulations to enforce this chapter.

SECTION 29. Notwithstanding any general or special law to the contrary, the first report of the health care workforce center required by section 25L of chapter 111 of the General Laws shall be filed on or before December 31, 2009 and shall focus on the primary care workforce, defined as physicians with a medical specialty in family medicine, internal medicine, pediatrics, and

obstetrics/gynecology or nurse practitioners practicing as primary care providers.

SECTION 30. Notwithstanding any general or special law to the contrary, the office of Medicaid, subject to appropriation and the availability of federal financial participation, and in consultation with the MassHealth payment policy advisory board, shall establish a medical home demonstration project. Within the demonstration project the office of Medicaid shall restructure its payment system to support primary care practices that use a medical home model and shall develop a program to support primary care providers in developing an organizational structure necessary to provide a medical home. The office of Medicaid shall work with Medicaid managed care organizations to develop and implement the project.

The office shall consider payment methodologies that support care-coordination through multi-disciplinary teams, including payment for care of patients with chronic diseases and the elderly, and that encourage services such as: (i) patient or family education for patients with chronic diseases; (ii) home-based services; (iii) telephonic communication; (iv) group care; and (v) culturally and linguistically appropriate care. Payment shall reward quality and improved patient outcomes.

The office shall identify practices, for participation in the project, that provide care to its patients using a medical home model, which at minimum shall include primary care practices with a multi-specialty team that provides patient-centered care coordination through the use of health information technology and chronic disease registries, across the patient's life-span and across all domains of the health care system and the patient's community.

The office shall promulgate regulations for the phase-in and implementation of this demonstration project.

The office, subject to appropriation and in coordination with the health care workforce center and the Massachusetts Academy of Family Physicians, shall develop a program to provide support to practices interested in developing an organizational structure necessary to provide a medical home.

The office shall conduct an annual project evaluation including documentation of cost savings achieved through implementation; health care screening rates, outcomes and hospitalization rates for patients with chronic illnesses such as pediatric asthma, diabetes, heart disease, hospitalization and readmission rates for the frail elderly. The office shall submit a report of the evaluation to the senate and house chairs of the joint committee on health care financing and the chairs of the senate and house committees on ways and means.

SECTION 31. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts shall expand the entering class at its medical school and increase residencies for medical school graduates for students committed to entering the primary care field and to working in underserved regions of the commonwealth. The trustees shall develop a master plan for expanding medical student enrollment and increasing internships and residencies for medical school graduates who are committed to primary care and work in underserved regions without reducing academic quality, together with a financial plan to support such expansion, and

shall report that plan to the clerk of the house of representatives who shall forward the same to the joint committee on health care financing and the house and senate committees on ways and means on or before January 1, 2009.

SECTION 32. Notwithstanding any general or special law to the contrary, the trustees of the University of Massachusetts, in conjunction with the state health education center at the University of Massachusetts medical center, shall establish and maintain an enhanced learning contract program available to medical students every academic year. The program shall provide full waivers of tuition and fees at the University of Massachusetts medical school. In exchange for the waivers, the contract shall require at least 4 years of service within the commonwealth in areas of primary care, public or community service or underserved areas, as determined by the health care workforce center established under section 25L of chapter 111 of the General Laws and the learning contract committee, in coordination with the area health education center and state and regional health planning agencies. If a student fails to perform the service required by an enhanced learning contract, that student shall pay the difference between the tuition paid and double the amount of the tuition charged together with an origination fee, interest per annum at prime rate as reported at the time of origination by the Federal Reserve, a margin and repayment fee as established by the board. No service or tuition loan repayment shall be required prior to the termination of any internship and residency requirements. Interest shall begin to accrue upon completion of the requirements for the degree. The commonwealth shall bear the cost of such tuition and fee waivers for enhanced learning contracts. The dean of the medical school shall report annually the number of students participating in enhanced learning contracts, the area of medicine within which payback is to be performed and the number of students utilizing the repayment option. The report shall also outline the effects of payback in the underserved areas of the commonwealth.

SECTION 33. (a) Notwithstanding any general or special law to the contrary, there shall be established and set up on the books of the commonwealth a separate fund to be known as the Massachusetts Nursing and Allied Health Workforce Development Trust Fund to which shall be credited any appropriations, bond proceeds or other monies authorized by the general court and specifically designated to be credited thereto, and additional funds, including federal grants or loans or private donations made available to the commissioner of higher education for this purpose. The department of higher education shall hold the fund in an account separate and apart from other funds or accounts. Amounts credited to the fund shall be expended by the commissioner of higher education to carry out subsection (b). Any balance in the fund at the close of a fiscal year shall be available for expenditure in subsequent fiscal years and shall not revert to the General Fund.
(b) the fund shall be used to develop and support, in consultation with the Massachusetts Nursing and Allied Health Workforce Development Advisory Committee, short-term and long-term strategies to increase the number of public and private higher education faculty and students who participate in programs that support careers in fields related to nursing and allied health. The commissioner of

higher education may expend such funds as may be necessary for the administration of the Massachusetts Nursing and Allied Health Workforce Development Initiative. In furtherance of these public purposes, the commissioner of higher education shall expend funds in the fund for activities that are calculated to increase the number of qualified nursing and allied health faculty and students and improve the nursing and allied health educational offerings available in public higher education institutions. Grants and other disbursements and activities may involve, without limitation, the University of Massachusetts, state and community colleges, private higher education institutions, private higher education institutions in partnership with public higher education institutions, business and industry partnerships, regional alliances, workforce investment boards, organizations granted tax-exempt status under section 501(c)(3) of the Internal Revenue Code and other community groups which promote the nursing profession. Grants and other disbursements and activities may support, without limitation: (i) the goal of rapidly increasing the number of nurses and allied health workers; (ii) enhancing the role of the system of public and private higher education, as institutions and in partnerships with other stakeholders, in meeting the short-term and long-term workforce challenges in the nursing and allied health professions; (iii) the development and use of innovative curricula, courses, programs and modes of delivering education in nursing and allied health professions for faculty and students in these fields; (iv) activities with the growing network of stakeholders in the nursing and allied health professions to create, implement, share and make broadly and publicly available best practices and innovative programs relative to instruction, development of partnerships and expanding and maintaining faculty and student involvement in careers in these fields; and (v) strengthening the institutional capacity to develop and implement long-term programs and policies to effectively respond to these challenges.

SECTION 34. Notwithstanding any general or special law to the contrary, the department of housing and community development, in consultation with the executive office of health and human services, the department of workforce development and the Massachusetts housing finance agency, shall establish a pilot grant or loan program to assist hospitals, community health centers, and physician practices in providing housing grants or loans for health care professionals who commit to practicing in underserved areas, identified by the health care workforce center, established under section 25L of chapter 111, and who meet income eligibility guidelines established by the department. Grants and loans may be used for: (i) purchasing a principal residence, including cooperative housing, that falls within price guidelines established by the department, including costs for down payments, mortgage interest rate buy-downs, closing costs and other costs determined to be eligible by the department; and (ii) payments for security deposits and advance payments for rental housing. The department, to the extent possible shall seek matching funds from hospitals and other private entities.

The department shall promulgate rules and regulations for the administration and enforcement of this section including, establishing provisions for eligibility, specifying the expenses for which grants and loans may be made, and determining the procedures necessary to qualify for assistance.

Two years after the commencement of the pilot program, the department shall report to the house and senate committees on ways and means, the joint committee on housing and the joint committee on health care financing, the results of the pilot program and shall recommend it for expansion, continuation or discontinuation.

SECTION 35. (a) Notwithstanding any general or special laws to the contrary, the division of health care finance and policy, in conjunction with the division of insurance, shall examine options and alternatives available to the commonwealth to provide regulation, oversight and disposition of the reserves, endowments and surpluses of health insurers and hospitals.
(b) The division shall conduct a study relative to health insurers, including health maintenance organizations and acute care and non-acute care hospitals. The study shall include, but not be limited to: (1) an analysis of the laws, regulations and other measures currently in effect in the commonwealth which regulate the amount, nature and disposition of surpluses held by or for the benefit of health insurers in excess of amounts reasonably anticipated to be required to pay claims, taking into account the level of such reserves and surpluses necessary to safeguard the solvency of health insurers against unanticipated events and other circumstances which may cause extraordinary medical losses; (2) an analysis of federal and state law, regulations and other measures currently in effect which regulate the amount, nature and disposition of surpluses and endowments held by or for the benefit of hospitals in excess of amounts reasonably anticipated to be required to perform and support services provided by the hospital and to guard against unanticipated events and other circumstances; (3) a review of recent fiscal practices and financial reporting by health insurers relative to reserves and surpluses and of hospital fiscal practices and financial reporting required by general or special law; (4) a comparison of the commonwealth's current statutes and regulations with those of other states which the commission deems to be reasonably comparable to those of the commonwealth; (5) a review and assessment of model acts and regulations and any other information which the commission finds to be relevant to its inquiry; and (6) a review of the method by which health insurers and hospitals fund community benefit programs including, but not limited to, the manner by which funding is regulated by other states as to the appropriate amount, monitoring and direction of such funding. In compiling this report, the division shall seek input from health plans and hospitals operating in the commonwealth, the attorney general, the executive office of health and human services, and the health care quality and cost council, established in section 16K of section 6A of the General Laws. In conducting its examination, the division shall, to the extent possible, obtain and use actual health plan and hospital data and such data shall be confidential and shall not be a public record under clause twenty-sixth of section 7 of chapter 4 of the General Laws or section 10 of chapter 66 of the General Laws.
(c) The division may contract with another entity with the requisite objective financial and actuarial expertise to assist the division in conducting its study.
(d) The division shall file a report of its findings and recommendations with the clerks of the senate and house of representatives, the house and senate committees on ways and means and the joint

committee on health care financing not later than July 1, 2009.

SECTION 36. Notwithstanding any general or special law to the contrary, on or before October 1, 2012, the department of public health shall adopt regulations requiring hospitals and community health centers, as a standard of eligibility for original licensure and renewal of licensure, to implement computerized physician order entry systems as defined by the department. The systems shall be certified by the Certification Commission for Healthcare Information Technology or a successor agency or organization established for the purpose of certifying that health information technology meets national interoperability standards.

SECTION 37. Notwithstanding any general or special law to the contrary, on or before October 1, 2015, the department of public health shall adopt regulations requiring hospitals and community health centers, as a standard of eligibility for original licensure and renewal of licensure, to implement interoperable electronic health records systems, as defined by the department. The system shall be certified by the Certification Commission for Healthcare Information Technology or a successor agency or organization established for the purpose of certifying that health information technology meets national interoperability standards.

SECTION 38. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall maximize enrollment of eligible persons in the MassHealth Senior Care Options program, the Program of All Inclusive Care for the Elderly, the Enhanced Community Options Program and the Community Choices program, or comparable successor programs, and shall develop dual eligible plans. For the purposes of this section, “dual eligible plans” shall be plans that offer similar coverage to Medicaid and Medicare-eligible disabled persons under age 65.
Not later than 6 months after the effective date of this act, the executive office of health and human services shall prepare a report identifying clinical, administrative and financial barriers to expanded dual eligible plans, and shall recommend steps to remove the barriers and implement the plans. Before finalizing the report, the executive office shall hold a public consultative session that shall include organizations representing seniors, organizations representing disabled persons, organizations representing health care consumers, organizations representing racial and ethnic minorities, health delivery systems and health care providers. The report shall include consideration of changes in procurement standards and MassHealth payment methodologies to promote enrollment in dual eligible plans. The report shall include estimates of the costs and benefits of implementing steps to remove barriers to expanded enrollment in dual eligible plans, including financial savings and improved quality of care.
The report shall be provided to the committee on health care financing and the house and senate committees on ways and means. Subject to appropriation, the executive office of health and human services shall implement any steps recommended by the report. Not later than 1 year after the filing

of the report, the executive office shall issue a progress statement on expanded enrollment in dual eligible plans.

SECTION 39. Notwithstanding any general or special law to the contrary, the division of insurance shall conduct an investigation and study of the costs of medical malpractice coverage for health care providers, as defined in section 193U of chapter 175 of the General Laws. The investigation and study shall include, but not be limited to, an examination and analysis of the following: (1) the availability and affordability of medical malpractice insurance; (2) the factors considered by medical malpractice insurers when increasing premiums; (3) options for decreasing premiums including, but not limited to, establishing a reinsurance pool with additional stop loss coverage, subsidizing premium payments of providers practicing in certain high-risk specialties or in specialties for which the cost of premiums represents a disproportionately high proportion of a health care provider's income, subsidizing premium payments of providers who do not qualify for group coverage rates and pay higher premiums for commercial market insurance and prorating premiums for providers who practice less than full-time; and (4) funding mechanisms that would facilitate the implementation of recommendations arising out of the study which may include, but shall not be limited to, charges borne by the health care industry or other entities. The division shall hold at least 2 public hearings to take testimony relating to the investigation and study, 1 of which shall be held outside the metropolitan Boston area. The division shall report its findings and recommendations to the clerk of the house of representatives who shall forward the same to the house and senate committee on ways and means and the joint committee on health care financing on or before January 1, 2009.

SECTION 40. Notwithstanding any general or special law to the contrary, the MassHealth payment policy advisory board, established in section 16M of chapter 6A of the General Laws, shall conduct a study of the need for an increase in Medicaid rates or bonuses for primary care physicians, nurse practitioners and subspecialists who provide primary care services, such as preventive care, certain evaluation and management procedures, early periodic screening, diagnosis and treatment and scheduled weekend and holiday services, in order to focus on prevention and wellness and delivery of primary care to identify illness earlier, to better manage chronic disease and to avoid costs associated with emergency room visits and hospitalizations. The committee shall report its findings, including recommendations for the amount of funding and the sources of funding, to the clerk of the house of representatives who shall forward the same to the joint committee on health care financing, and the house and senate committees on ways and means on or before January 1, 2009.

SECTION 41. Notwithstanding any general or special law to the contrary, the executive office of health and human services, in consultation with the health care quality and cost council, commission on end-of-life care established by section 480 of chapter 159 of the Acts of 2000, and the Betsy Lehman Center for Patient Safety and the Reduction of Medical Errors, shall convene an expert panel on end-of-life care for patients with serious chronic illnesses. The panel shall investigate and

study health care delivery for these patients and the variations in delivery of such care among health care providers in the commonwealth. For the purposes of this investigation and study, “health care providers” shall mean facilities and health care professionals licensed to provide acute inpatient hospital care, outpatient services, skilled nursing, rehabilitation and long-term hospital care, home health care and hospice services. The panel shall identify best practices for end-of-life care, including those that minimize disparities in care delivery and variations in practice or spending among geographic regions and hospitals, and shall present recommendations for any legislative, regulatory, or other policy changes necessary to implement its recommendations.

SECTION 42. Notwithstanding any general or special law to the contrary, on or before January 1, 2009, the executive office of health and human services, in consultation with the commission on end–of-life care established by section 480 of chapter 159 of the acts of 2000, shall initiate a public awareness campaign to highlight the importance of end-of-life care planning. The campaign shall include, but not be limited to, dissemination of information and other activities that educate the public about existing options for care at the end of life and how to communicate their end-of-life care wishes to family members and health care providers.

SECTION 43. Notwithstanding any general or special law to the contrary, the executive office of health and human services, in consultation with the commission on end-of-life care established by section 480 of chapter 159 of the acts of 2000, shall establish a pilot program to test the implementation of the physician order for life-sustaining treatment paradigm program to assist individuals in communicating end-of-life care directives across care settings in at least 1 region of the commonwealth. The pilot program shall include educational outreach to patients, families, caregivers and health care providers regarding the physician order for life-sustaining treatment paradigm program. The executive office of health and human services, in conjunction with the end-of-life commission, shall develop measures to test the success of the pilot program and make recommendations for the establishment of a state-wide program.

SECTION 44. (a) Notwithstanding any general or special law to the contrary, there shall be a special commission on the health care payment system that shall investigate reforming and restructuring the system to provide incentives for efficient and effective patient-centered care and to reduce variations in the quality and cost of care.
(b) The commission shall consist of the secretary of administration and finance and the commissioner of health care finance and policy, who shall serve as co-chairs, the executive director of the group insurance commission, 1 person to be appointed by the senate president, 1 person to be appointed by the speaker of the house, and 5 members to be appointed by the Governor, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a

representative of the Massachusetts Medical Society, and 1 of whom shall be a health economist or expert in the area of payment methodology.

The commission shall adopt rules and establish procedures it considers necessary for the conduct of its business. The commission may expend funds as may be appropriated or made available for its purposes. No action of the commission shall be considered official unless approved by a majority vote of the commission.

(c) The commission (i) shall examine payment methodologies and purchasing strategies, including, but not limited to, alternatives to fee-for-service models such as blended capitation rates, episodes-of-care payments, medical home models, and global budgets; pay-for-performance programs; tiering of providers; and evidence-based purchasing strategies, (ii) recommend a common transparent payment methodology that promotes coordination of care and chronic disease management; rewards primary care physicians for improving health outcomes; reduces waste and duplication in clinical care; decreases unnecessary hospitalizations and use of ancillary services; and provides appropriate reimbursement for investment in health information technology that reduces medical errors and enables coordination of care, and (iii) recommend a plan for the implementation of the common payment methodology across all public and private payers in the commonwealth, including a plan under which the commonwealth shall seek a waiver from federal Medicare rules to facilitate the implementation of the common payment system.

(d) In making its investigation, the commission shall consult with the health care quality and cost council, the division of health care finance and policy, health care economists, and others individuals or organizations with expertise in state and federal health care payment methodologies and reforms. The commission shall use data and recommendations gathered in the course of these consultations as a basis for its findings and recommendations.

(e) The commission shall file a report of its findings and recommendations, including any proposed legislation needed to implement the recommendations.

(f) The attorney general shall, in consultation with the commissioner of health care finance and policy, adopt rules, regulations or guidelines necessary and appropriate to provide active state supervision for the administration of this section. The commissioner of health care finance and policy may terminate any action taken pursuant to this section that does not support the purposes of this section or the terms of the regulations promulgated pursuant to this section that provide oversight for the commission.

Before a final vote on any recommendations, the commission shall consult with a reasonable variety of parties likely to be affected by its recommendations, including, but not limited to, the office of Medicaid, the division of health care finance and policy, the commonwealth health insurance connector, the Massachusetts Council of Community Hospitals, Inc., the Massachusetts League of Community Health Centers, Inc., 1 or more academic medical centers, 1 or more hospitals with a high proportion of public payors, 1 or more Taft-Hartley plans, 1 or more self-insured plans with membership of more than 500, the Massachusetts Municipal Association, Inc. and organizations representing health care consumers.

The commission shall hold its first meeting no later than September 15, 2008 and shall file the report of its findings and recommendations together with legislation, if any, with the clerks of the senate and the house of representatives and with the governor no later than April 1, 2009.
Any person or entity acting under the authority of any rule, regulation or guideline adopted pursuant to this section shall be engaged in action under state policy and shall be immune from antitrust liability to the same degree and extent as the Commonwealth.

SECTION 45. Any entity providing ambulatory surgical center services which is in operation or under construction, as determined by the department of public health, on the effective date of this act shall be exempt from the determination of need requirement of section 53G of chapter 111 of the General Laws and shall be eligible, pursuant to said section 53G of said chapter 111, to make application to the department for a clinic license for up to 6 months after the effective date of regulations adopted by the department pursuant to said section 53G of said chapter 111.

SECTION 46. Section 7 shall apply to any project seeking written approval of final architectural plans, pursuant to section 51 of chapter 111 of the General Laws 6 months or more after the effective day of this act.

SECTION 47. Notwithstanding any general or special law to the contrary, the department of public health shall review the Mass COMM Percutaneous Coronary Intervention trial and shall determine any adjustments or changes the department may enact to accelerate the trial without jeopardizing the validity of the study. The department shall immediately take action to implement such changes and shall report its findings and any necessary legislative recommendations to the joint committee on health care financing and the house and senate committees on ways and means no later than October 31, 2008.

SECTION 48. Notwithstanding any general or special law to the contrary, the department of public health shall promulgate regulations necessary to implement, administration and enforcement of section 4N of chapter 111 of the General Laws in accordance with chapter 30A on or before October 1, 2008, and shall begin implementation of the outreach and education program established under said section 4N on or before January 1, 2009.

SECTION 49. Notwithstanding any general or special law to the contrary, the bureau of managed care within the division of insurance shall convene the first advisory committee required under section 5B of chapter 176O of the General Laws on or before January 1, 2009.

SECTION 50. Notwithstanding any general or special law to the contrary, the secretary of administration and finance and the secretary of health and human services shall prepare and submit a report to the general court about the allocation for and use of state funds by acute care hospitals,

non-acute care hospitals, Medicaid managed care organizations, other managed care organizations, community health centers and carriers contracting with the commonwealth health insurance connector authority to provide coverage under chapter 118H or any other publicly funded program. The report shall include: (1) a comprehensive review of the current manner, amount and purposes of annual state funding received by those entities, including a description of the source of the funding; (2) an assessment of the change in total state funding for those entities over the past 5 years, with particular attention paid to the impact of chapter 58 of the acts of 2006; (3) an assessment of how those entities use state funds; (4) an assessment of whether the current payment structure assures the delivery of quality health care in the most cost-effective way; (5) an analysis of financial and management practices of those entities by benchmarking performance with respect to quality and cost effectiveness against national performance levels and similar health care providers in the commonwealth; (6) identification of common factors that may contribute to the fiscal instability of those entities; (7) recommendations for the development of performance and operational benchmarks; (8) recommendations for ensuring that the entities are spending state and other funds in a fiscally-responsible manner and providing quality care; (9) recommendations for legislative and other action necessary to strengthen state oversight and ensure greater accountability of state resources; (10) an assessment of the manner in which hospitals seek payment from consumers, including an analysis of the impact that court filing fees have on their ability to collect payment; and (11) recommendations for regulations regarding the due diligence that facilities shall exercise in seeking to collect payment from consumers before seeking reimbursement from the commonwealth.

SECTION 51. Notwithstanding any general or special law to the contrary, on or before July 31, 2012, the e-Health institute, in consultation with the health information technology council established by section 6D of chapter 40J, shall submit a report to the joint committee on health care financing and the senate and house committees on ways and means on the status of health information technology in the commonwealth. The report shall include the status of: (i) the implementation and use of electronic health records systems, such as rate of provider participation; (ii) the statewide interoperable electronic health records network and its capacity to exchange health information between and among components of the health system, with special focus on ambulatory care providers; (iii) the security and privacy of health information technology developed and disseminated through activities of the council; and (iv) the impact of health information technology on health care quality, health outcomes of patients, and health care costs.

SECTION 52. Notwithstanding any general or special law to the contrary, the health e-Health institute and the health information technology oversight council, established by section 6D of chapter 40J of the General Laws, shall have as its goal full implementation of electronic health records systems and the statewide interoperable electronic health records network by January 1, 2015.

SECTION 53. Notwithstanding any general or special law to the contrary, the secretary of health and human services, in consultation with the health care quality and cost council, shall: (i) examine the feasibility of the commonwealth entering into an interstate compact with 1 or more states to establish an independent entity to research the comparative effectiveness of medical procedures, drugs, devices, and biologics, so that research results can be used as a basis for health care purchasing and payment decisions, and (ii) make recommendations concerning the entity's design. The secretary shall consider existing state and country models, including, but not limited to, the Washington State Health Care Authority's Health Technology Assessment program, the National Institute for Health and Clinical Excellence in Britain, and the Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen in Germany. The secretary shall file a report with the results of the study together with legislation, if any, with the clerk of the senate and the clerk of the house of representatives on or before March 30, 2009.

SECTION 54. Item 1599-2008 of chapter 182 of the acts of 2008 is hereby amended by striking the following words:- , inspector general's office.

SECTION 55. Chapter 182 of the acts of 2008 is hereby amended by striking out section 10.

SECTION 56. Chapter 182 of the acts of 2008 is hereby amended in section 87 by striking out the words:- "established in section 10 of this act".

SECTION 57. Section 10 shall take effect on October 1, 2012.

SECTION 58. Section 15 shall take effect on January 1, 2015.

SECTION 59. Subsection (d) of section 61 of chapter 118E of the General Laws, as appearing in section 18 shall take effect on January 1, 2011.

SECTION 60. Sections 19 and 27 shall take effect on July 1, 2012.

SECTION 61. Subsection (d) of section 5A of chapter 176O of the General Laws, as appearing in section 26 shall take effect on January 1, 2011.

SECTION 62. Sections 14, 28 and 42 shall take effect on January 1, 2009.

Approved August 10, 2008

Senate, No. 2585

[Senate, July 30, 2010-- Report of the committee of conference on the disagreeing votes of the two branches, with reference to the House amendments to the Senate Bill to promote cost containment, transparency and efficiency in the provision of quality health insurance for individuals and small businesses (Senate, No. 2447) (*amended by the House* by striking out all after the enacting clause and inserting in place thereof the text of House document numbered 4924")]

The Commonwealth of Massachusetts

IN THE YEAR OF TWO THOUSAND AND TEN

AN ACT TO PROMOTE COST CONTAINMENT, TRANSPARENCY AND EFFICIENCY IN THE PROVISION OF QUALITY HEALTH INSURANCE FOR INDIVIDUALS AND SMALL BUSINESSES

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to provide forthwith for the containment, transparency and efficiency in the provision of quality health insurance for individuals and small businesses, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health.

Be it enacted by the Senate and House of Representatives in General Court assembled,

And by the authority of the same, as follows:

SECTION 1. Section 38C of chapter 3 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following subsection:-

(e) The division of health care finance and policy shall issue a comprehensive report at least once every 4 years on the cost and public health impact of all existing mandated benefits. In conjunction with this review, the division shall consult with the department of public health and the University of Massachusetts Medical School in a clinical review of all mandated benefits to ensure that all mandated

benefits continue to conform to existing standards of care in terms of clinical appropriateness or evidence-based medicine. The division may file legislation that would amend or repeal existing mandated benefits that no longer meet these standards.

SECTION 2. Section 16K of chapter 6A of the General Laws, as so appearing, is hereby amended by striking out subsections (a) to (c), inclusive, and inserting in place thereof the following 3 subsections:-

(a) There shall be established a health care quality and cost council, which 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. The council shall promote public transparency of the quality and cost of health care in the commonwealth, and shall seek to support the long-term sustainability of health care reform in the commonwealth by developing recommendations for containing health care costs, while facilitating access to information on health care quality improvement efforts. The council shall disseminate health care quality and cost data to consumers, health care providers and insurers through a consumer health information website under subsections (e) and (g); establish cost containment goals under subsection (h); and coordinate ongoing quality improvement initiatives under subsection (i).

(b) The council shall consist of 19 members and shall be comprised of: (1) 9 ex-officio members, including the secretary of health and human services, the secretary of administration and finance, the state auditor, the inspector general, the attorney general, the commissioner of insurance, the commissioner of health care finance and policy, the commissioner of public health and the executive director of the group insurance commission, or their designees; and (2) 10 representatives of nongovernmental organizations to be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of the Institute for Healthcare Improvement recommended by the organization's board of

directors, 1 of whom shall be a representative of the Massachusetts chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, Inc., 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy from a foundation or academic institution, 1 of whom shall be a representative of a non-governmental purchaser of health insurance, 1 of whom shall be an organization representing the interests of small businesses with fewer than 50 employees, 1 of whom shall be an organization representing the interests of large businesses with 50 or more employees and 1 of whom shall be a clinician licensed to practice in the commonwealth. At least 2 members of the council shall be clinicians licensed to practice in the commonwealth. Members of the council shall vote annually to elect a chair and an executive committee, which shall consist of 4 council members and the chair. The executive committee shall meet as required to fulfill the mission of the council. Members of the council shall be appointed for terms of 3 years and shall serve until the term is completed or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties which may include reimbursement for reasonable travel and living expenses while engaged in council business. All council members shall be subject to chapter 268A; provided, however, 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 further 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 council member having such interest or involvement may participate in any decision relating to such organization.

(c) All meetings of the council shall comply with chapter 30A. The council may, subject to chapter 30B and subject to appropriation, procure equipment, office space, goods and services.

The executive office of health and human services may provide staff and administrative support as requested by the council; provided, however, that all work completed by the executive office of health

and human services shall be subject to approval by the council . The council shall appoint an executive director to oversee the operation and maintenance of the website, ensure compliance with the requirements of this section, and coordinate work completed by the executive office of health and human services and may, subject to appropriation, employ such additional staff or consultants as it deems necessary.

The council shall promulgate rules and regulations and may adopt by-laws necessary for the administration and enforcement of this section.

SECTION 3. Said section 16K of said chapter 6A, as so appearing, is hereby further amended by striking out subsections (h) and (i), as so appearing, and inserting in place thereof the following 2 subsections:-

(h) The council, in consultation with its advisory committee, shall develop annual health care cost containment goals. The goals shall be designed to promote affordable, high-quality, safe, effective, timely, efficient, equitable and patient centered health care. The council shall also establish goals that are intended to reduce health care disparities in racial, ethnic and disabled communities. In establishing cost containment goals, the council shall utilize claims data collected from carriers under this section, and information gathered as part of the division of health care finance and policy's public hearings on health care costs under section 6 ½ of chapter 118G. For each goal, the council shall identify: (i) the parties that will be impacted;(ii) the agencies, departments, boards or councils of the commonwealth responsible for overseeing and implementing the goals; (iii) the steps needed to achieve the goals;(iv) the projected costs associated with implementing the goals; (v) and the potential cost savings, both short and long-term, attributable to the goals. The council may recommend legislation or regulatory changes to achieve these goals. The council shall publish a report on the progress towards achieving the costs containment goals.

(i) The council, in consultation with its advisory committee, shall coordinate and compile data on quality improvement programs conducted by state agencies and public and private health care

organizations. The council shall consider programs designed to: (i) improve patient safety in all settings of care; (ii) reduce preventable hospital readmissions; (iii) prevent the occurrence of and improve the treatment and coordination of care for chronic diseases; and (iv) reduce variations in care. The council shall make such information available on the council's consumer health information website. The council may recommend legislation or regulatory changes as needed to further implement quality improvement initiatives.

SECTION 4. Section 2 of chapter 32A of the General Laws, as amended by section 64 of chapter 25 of the acts of 2009 , is hereby amended by adding the following subsection:-

(i) "Wellness program", a program designed to measure and improve individual health by identifying risk factors, principally through diagnostic testing and establishing plans to meet specific health goals which include appropriate preventive measures. Risk factors may include but shall not be limited to demographics, family history, behaviors and measured biometrics.

SECTION 5. Said chapter 32A is hereby further amended by adding the following section:-

Section 25. The commission shall, subject to appropriation, negotiate with and purchase, on such terms as it deems to be in the best interest of the commonwealth and its employees, from 1 or more entities that can manage a wellness program covering persons in the service of the commonwealth and their dependents, and shall execute all agreements or contracts pertaining to the program. The commission may negotiate a contract for such term not exceeding 5 years as it may, in its discretion, deem to be the most advantageous to the commonwealth; provided, however that the program shall be able to evaluate individual and aggregate data, give employees access to their individual information confidentially and allow the commission to receive collective reports summarizing baseline and ongoing data regarding the behavior and well being of enrollees. The commission may reduce premiums or co-payments or offer other incentives to encourage enrollees to comply with the wellness program goals.

Beginning 1 year after the end of the fiscal year in which the commission has implemented the wellness program, the commission shall submit an annual report to the governor, the secretary of health and human services, the secretary of administration and finance, the chairs of the joint committee on health care financing, chairs of the house and senate committees on ways and means, the speaker of the house of representatives and the senate president. The report shall include the collective results, including, but not limited to, the level of participation among employees, incentives provided for participation, the number and type of screenings and diagnostic tests conducted, the instance of undiagnosed risks defined as out of range diagnostic tests and number of employees seeking and receiving preventative treatment. The commission shall use this information in the negotiating and purchasing, on such terms as it deems in the best interest of the commonwealth and its employees, from 1 or more insurance companies, savings banks or non-profit hospital or medical service corporations, of a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth and group general or blanket insurance providing hospital, surgical, medical, dental and other health insurance benefits covering persons in the service of the commonwealth and their dependents.

Beginning 1 year after the end of the fiscal year in which the commission has implemented the wellness program, the commission shall annually submit a report to the governor, secretary of administration and finance, the chairs of the joint committee on health care financing, the chairs of the house and senate committees on ways and means, the speaker of the house of representatives and the senate president on the savings that have been achieved in procuring such insurance policies since implementing the wellness program.

SECTION 6. Subsection (b) of section 9of chapter 94C of the General Laws, as appearing in the 2008 Official Edition, is hereby by adding the following paragraph:-

This section shall not be construed to prohibit a physician or an optometrist from the in-office dispensing and sale of therapeutic contact lenses as long as the medication contained in such lenses is within the profession's designated scope of practice.

For the purposes of this section, "therapeutic contact lenses" shall mean contact lenses which contain 1 or more medications and which deliver such medication to the eye.

SECTION 7. Chapter 111 of the General Laws is hereby amended by inserting after section 25O the following section:-

Section 25P Every health care provider, as defined by section 1 or otherwise licensed under chapter 112, shall track and report quality information at least annually under regulations promulgated by the department.

SECTION 8. Section 217 of said chapter 111, as appearing in the 2008 Official Edition, is hereby amended by inserting after the word "plans", in line 33, the following words:– ; and

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

SECTION 9. Said chapter 111 is hereby further amended by adding the following section: -

Section 222. There shall be a commission on falls preventions within the department. The commission shall consist of the commissioner of public health or the commissioner's designee, who shall chair the commission; the secretary of elder affairs or the secretary's designee; the director of MassHealth

or the director's designee; and 8 members to be appointed by the governor, 1 of whom shall be a member of the Home Care Alliance of Massachusetts, Inc., 1 of whom shall be a member of the AARP, 1 of whom shall be a member of the Massachusetts Senior Care Association, Inc., 1 of whom shall be a member of the Massachusetts Association of Councils on Aging, Inc. 1 of whom shall be a member of the Massachusetts Medical Society Alliance, Inc., 1 of whom shall be a member of the Massachusetts Assisted Living Facilities Association, 1 of whom shall be a member of Mass Home Care and 1 of whom shall be a member of the Massachusetts Pharmacists Association Foundation, Inc.

The commission on falls prevention shall make an investigation and comprehensive study of the effects of falls on older adults and the potential for reducing the number of falls by older adults. The commission shall monitor the effects of falls by older adults on health care costs, the potential for reducing the number of falls by older adults and the most effective strategies for reducing falls and health care costs associated with falls. The commission shall:

(1) consider strategies to improve data collection and analysis to identify fall risk, health care cost data and protective factors;

(2) consider strategies to improve the identification of older adults who have a high risk of falling;

(3) consider strategies to maximize the dissemination of proven, effective fall prevention interventions and identify barriers to those interventions;

(4) assess the risk and measure the incidence of falls occurring in various settings;

(5) identify evidence-based strategies used by long-term care providers to reduce the rate of falls among older adults and reduce the rate of hospitalizations related to such falls;

(6) identify evidence-based community programs designed to prevent falls among older adults;

(7) review falls prevention initiatives for community-based settings; and

(8) examine the components and key elements of the above falls prevention initiatives, consider their applicability in the commonwealth and develop strategies for pilot testing, implementation and evaluation.

The commission on falls prevention shall submit to the secretary of health and human services and the joint committee on health care financing, not later than September 22, annually, a report that includes findings from the commission's review along with recommendations and any suggested legislation to implement those recommendations. The report shall include recommendations for:

(1) intervention approaches, including physical activity, medication assessment and reduction of medication when possible, vision enhancement and home-modification strategies;

(2) strategies that promote collaboration between the medical community, including physicians, long-term care providers and pharmacists to reduce the rate of falls among their patients;

(3) programs that are targeted to fall victims who are at a high risk for second falls and that are designed to maximize independence and quality of life for older adults, particularly those older adults with functional limitations;

(4) programs that encourage partnerships to prevent falls among older adults and prevent or reduce injuries when falls occur; and

(5) programs to encourage long-term care providers to implement falls- prevention strategies which use specific interventions to help all patients avoid the risks for falling in an effort to reduce hospitalizations and prolong a high quality of life.

SECTION 10. Section 66B of chapter 112 of the General Laws is hereby amended after the third paragraph by inserting the following:-

This section shall not be construed to prohibit an optometrist from the in-office dispensing and sale of therapeutic contact lenses as long as the medication contained in such lenses is within the profession's designated scope of practice.

For the purposes of this section, "therapeutic contact lenses" shall mean contact lenses which contain 1 or more medications and which deliver such medication to the eye.

SECTION 11. Section 1 of chapter 118G of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Health maintenance organization" the following definition:-

"Health status adjusted total medical expenses", the total cost of care for the patient population associated with a provider group based on allowed claims for all categories of medical expenses and all non-claims related payments to providers, adjusted by health status, and expressed on a per member per month basis, as calculated under section 6 and the regulations promulgated by the commissioner.

SECTION 12. Said section 1 of said chapter 118G, as so appearing, is hereby further amended by inserting after the definition of "Purchaser" the following definition:-

"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 6 of chapter 118G and regulations promulgated by the commissioner.

SECTION 13. Section 6 of said chapter 118G of the General Laws is hereby amended by striking out the fourth and fifth paragraphs, as so appearing, and inserting in place thereof the following 3 paragraphs: -

The division 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: (i) 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; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan designs for each plan; (iv) 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; (v) information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels; (vii) health status adjusted total medical expenses by provider group and local practice group and zip code calculated according to a uniform methodology; (viii) relative prices paid to every hospital, 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 and calculated according to a uniform methodology; and (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology.

The division shall require the submission of data and other information from public health care payers including, but not limited to: (i) average premium rates for health insurance plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums; (ii) average annual per-member per-month payments for enrollees in MassHealth primary care clinician and fee for service programs; (iii) summaries of plan designs for each plan or program; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan or program; (v) where appropriate, information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in

these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid; (vii) health status adjusted total medical expenses by provider group and local practice group and zip code calculated according to a uniform methodology; (viii) relative prices paid to every hospital, 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 and calculated according to a uniform methodology.

The division shall require the submission of data and other such information from each acute care hospital on hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology.

The division shall publicly report and place on its website information on health status adjusted total medical expenses, relative prices and hospital inpatient and outpatient costs, including direct and indirect costs under this section on an annual basis; provided, however, that at least 10 days prior to the public posting or reporting of provider specific information the affected provider shall be provided the information for review. The division shall request from the federal Centers for Medicare and Medicaid Services the health status adjusted total medical expenses of provider groups that serve Medicare patients.

SECTION 14. Section 6C of said chapter 118G is hereby amended by striking out subsection (c), as amended by section 9 of chapter 65 of the acts of 2009, and inserting in place thereof the following subsection:-

(c) Information that indentifies individual employees by name or health insurance status shall not be a public record, but the information shall be exchanged with the department of revenue, the commonwealth health insurance connector authority, and the health care access bureau in the division of insurance under an interagency services agreement for the purposes of enforcing this section, sections 3, 6B and 18B of chapter 118H, and sections 3 to 7A, inclusive, of chapter 176Q. An employer who

knowingly falsifies or fails to file with the division any information required by this section or by any regulation promulgated by the division shall be punished by a fine of not less than $1,000 not more than $5,000.

SECTION 15. Section 47H of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out the last sentence and inserting in place thereof the following 2 sentences:- For purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

SECTION 16. Section 8K of chapter 176A of the General Laws, as so appearing, is hereby amended by striking out the last sentence and inserting in place thereof the following 2 sentences:- For purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

SECTION 17. Section 4J of chapter 176B of the General Laws, as so appearing, is hereby amended by striking out the last sentence and inserting in place thereof the following 2 sentences:- For purposes of this section, ‘infertility’ shall mean the condition of an individual who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 6 months if the female is over the age of 35. For purposes of meeting the criteria for infertility in this

section, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the 1 year or 6 month period, as applicable.

SECTION 18. Section 3 of chapter 176D of the General Laws, as so appearing, is hereby amended by striking out clause (4) and inserting in place thereof the following clause:-

(4) Boycott, coercion and intimidation: (a) entering into an agreement to commit, or by concerted action committing, an act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; (b) an refusal by a nonprofit hospital service corporation, medical service corporation, insurance or health maintenance organization to negotiate, contract or affiliate with a health care facility or provider because of such facility's or provider's contracts, type of provider licensure or affiliations with any other nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization; or (c) an nonprofit hospital service corporation, medical service corporation, insurance company or health maintenance organization establishing the price to be paid to any health care facility or provider by reference to the price paid, or the average of prices paid, to such facility or provider under a contract or contracts with any other nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization or preferred provider arrangement.

SECTION 19. Said chapter 176D is hereby further amended by striking out section 3A, as so appearing, and inserting in place thereof the following section:-

Section 3A. The following shall be unfair methods of competition and unfair or deceptive acts or practices in the business of insurance by entities organized under chapters 176A, 176B, 176G and 176I or licensed under chapter 175: (i) entering into any agreement to commit or by any concerted action committing any act of, boycott, coercion, intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance; (ii) refusal to enter into a contract with a health

care facility on the basis of the facility's religious affiliation; (iii) seeking to set the price to be paid to any health care facility or provider by reference to the price paid, or the average of prices paid, to that health care facility or provider under a contract or contracts with any other nonprofit hospital service corporation, medical service corporation, insurance company, health maintenance organization or preferred provider arrangement; (iv) refusal to contract or affiliate with a health care facility solely because the facility does not provide a specific service or range of services; (v) selecting or contracting with a health care facility or provider not based primarily on cost, availability and quality of covered services; (vi) refusal to enter into a contract with a health care facility solely on the basis of the facility's governmental affiliation; and (vii) arranging for an individual employee to apply for individual health insurance coverage, as defined in chapter 176J, for the purpose of separating that employee from group health insurance coverage to reduce costs for an employer sponsored health plan provided in connection with the employee's employment.

SECTION 20. Section 1 of said chapter 176J, as so appearing, is hereby amended by striking out the definition of "Eligible individual" and inserting in place thereof the following definition:-

"Eligible individual", an individual who is a resident of the commonwealth and who is not seeking individual coverage to replace an employer-sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage.

SECTION 21. Said section 1 of chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Prototype plan" the following definition:-

"Qualified association", a Massachusetts nonprofit or not-for-profit corporation or other entity organized and maintained for the purposes of advancing the occupational, professional, trade or industry interests of its association members, other than that of obtaining health insurance, and that has been in active existence for at least 5 years, that comprises at least 100 association members and membership in

which is generally available to potential association members of such occupation, profession, trade or industry without regard to the health condition or status of a prospective association member or the employees and dependents of a prospective association member.

SECTION 22. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of "Resident" the following definition:-

"Small business group purchasing cooperative", or "group purchasing cooperative", a Massachusetts nonprofit or not-for-profit corporation or association, approved as a qualified association by the commissioner under section 13, all the members of which are part of a qualified association which negotiates with 1 or more carriers for the issuance of health benefit plans that cover employees, and the employees' dependents, of the qualified association's members.

SECTION 23. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by adding the following definition:-

"Wellness program", or "health management program", an organized system designed to improve the overall health of participants through activities that may include, but shall not be limited to, education, health risk assessment, lifestyle coaching, behavior modification and targeted disease management.

SECTION 24. Subsection (a) of section 3 of said chapter 176J, as so appearing, is hereby amended by striking out clause (2) and inserting in place thereof the following clause:-

(2) A carrier may establish an age rate adjustment that applies to both eligible individuals and eligible small groups; provided, however, that the carrier applies the rate adjustment on a year-to-year basis for both eligible individuals and eligible small groups.

SECTION 25. Said section 3 of said chapter 176J, as so appearing, is hereby further amended by adding the following subsection:-

(f) The commissioner may conduct an examination of the rating factors used in the small group health insurance market in order to identify whether any expenses or factors inappropriately increase the cost in relation to the risks of the affected small group. The commissioner may adopt changes to the small group regulation each July 1 for rates effective each subsequent January 1 to modify the derivation of group base premium rates or of any factor used to develop individual group premiums.

SECTION 26. Subsection (a) of section 4 of said chapter 176J, as so appearing, is hereby amended by striking out paragraphs (2) to (4), inclusive, and inserting in place thereof the following 3 paragraphs:-

(2) A carrier shall enroll eligible individuals and eligible persons, as defined in section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg-41(b), into a health plan if such individuals or persons request coverage within 63 days of termination of any prior creditable coverage. Coverage shall become effective within 30 days of the date of application, subject to reasonable verification of eligibility.

(3) A carrier shall enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the mandatory biannual open enrollment period for eligible individuals and the eligible dependents of those individuals. Each year, the first open enrollment period shall begin on January 1 and end on February 15. The second open enrollment period shall begin on July 1 and end on August 15. All coverage shall become effective on the first day of the month following enrollment. The commissioner shall promulgate regulations for the open enrollment periods. For a Trade Act/HCTC-eligible persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more that 6 months following the individual's effective date of coverage if the Trade Act/HCTC-eligible person has had less than 3 months of continuous health coverage before becoming eligible for the health coverage tax credit; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.

(4) No policy may require any waiting period if the eligible individual has not had any creditable coverage for the 18 months prior to the effective date of coverage. Notwithstanding paragraph (3), an eligible individual who does not meet the requirements of paragraph (2) may seek an enrollment waiver to permit enrollment not during a mandatory open enrollment period. Enrollment waivers shall be administered and granted by the office of patient protection established by section 217 of chapter 111.

SECTION 27. Said subsection (a) of said section 4 of said chapter 176J is hereby further amended by striking out paragraph (3), as appearing in section 26, and inserting in place thereof the following paragraph:-

(3) A carrier shall enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the mandatory annual open enrollment period for eligible individuals and their dependents. Each year, the open enrollment period shall begin on July 1 and end on August 15. A carrier shall only enroll an eligible individual who does not meet the requirements of paragraph (2) into a health benefit plan during the open enrollment period. All coverage shall become effective on the first day of the month following enrollment. The commissioner shall promulgate regulations for the open enrollment period permissible under this section. With respect to Trade Act/Health Coverage Tax Credit Eligible Persons, a carrier may impose a pre-existing condition exclusion or waiting period of no more that 6 months following the individual's effective date of coverage if the Trade Act/Health Coverage Tax Credit Eligible Person has had less than 3 months of continuous health coverage before becoming eligible for the health care tax credit; or a break in coverage of over 62 days immediately before the date of application for enrollment into the qualified health plan.

SECTION 28. Subsection (b) of said section 4 of said chapter 176J, as appearing in the 2008 Official Edition, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:

(1) Notwithstanding any other provision in this section, a carrier may deny an eligible individual or eligible small group enrollment in a health benefit plan if the carrier certifies to the commissioner that the carrier intends to discontinue selling that health benefit plan to new eligible individuals or eligible small businesses. A health benefit plan closed to new members may be cancelled and discontinued to all members upon the approval of the commissioner of insurance when such plan has been closed to enrollment for new individuals and small groups and the carrier has complied with the requirements of 42 U.S.C. Sec. 300gg-12; provided, however, that cancellation of the plan shall be effective on the individual or small group's next enrollment anniversary after such cancellation is approved by the commissioner of insurance. The commissioner may promulgate regulations prohibiting a carrier from using this paragraph to circumvent the intent of this chapter.

SECTION 29. Said chapter 176J is hereby further amended by striking out section 6, as so appearing, and inserting in place thereof the following section:-

Section 6. (a) Notwithstanding any general or special law to the contrary, the commissioner may approve health insurance policies submitted to the division of insurance for the purpose of being provided to eligible individuals or eligible small businesses. These health insurance policies shall be subject to this chapter and may include networks that differ from those of a health plan's overall network. The commissioner shall adopt regulations regarding eligibility criteria. These eligibility criteria shall require that health insurance policies that exclude mandated benefits shall only be offered to small businesses which did not provide health insurance to its employees as of April 1, 1992. These eligibility criteria shall also provide that small businesses shall not have any health insurance policies that exclude mandated benefits for more than a 5-year period.

(b) Notwithstanding any general or special law to the contrary, the commissioner shall require carriers offering health benefit plans to eligible small businesses and eligible individuals to submit information as required by the commissioner, which shall include the current and projected medical loss

ratio for plans the components of projected administrative expenses and financial information, including, but not limited to:

(i) underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(ii) marketing and sales expenses, including, but not limited to, advertising, member relations, member enrollment and all expenses associated with producers, brokers and benefit consultants;

(iii) claims operations expenses, including, but not limited to, adjudication, appeals, settlements and expenses associated with paying claims;

(iv) medical administration expenses, including, but not limited to, disease management, utilization review and medical management;

(v) network operations expenses, including, but not limited to, contracting, hospital and physician relations and medical policy procedures;

(vi) charitable expenses, including, but not limited to, contributions to tax-exempt foundations and community benefits;

(vii) state premium taxes;

(viii) board, bureau and association fees;

(ix) depreciation; and

(x) miscellaneous expenses described in detail by expense, including any expense not included in clauses (i) to (ix), inclusive.

(c) Notwithstanding any general or special law to the contrary, the commissioner may require carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, to file all changes to small group product base rates and to small group rating factors at

least 90 days before their proposed effective date. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. Rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

(d) For base rate changes filed under this section, if a carrier files a base rate whose administrative expense loading component, not including taxes and assessments, increases by more than the most recent calendar year's percentage increase in the New England medical CPI or if a carrier's reported contribution to surplus exceeds 1.9 per cent or if the aggregate medical loss ratio for all plans offered under this chapter is less than 88 per cent , such carrier's rate, in addition to being subject to all other provisions of this chapter, shall be presumptively disapproved as excessive by the commissioner as set forth in this subsection, with the exception of any carrier whose Risk Based Capital Ratio falls below 300% for the most recent four consecutive quarters. For such carriers the reported contribution to surplus may not exceed 2.5 per cent.

If, however, a carrier's base rates are presumptively disapproved for failure to meet only the aggregate medical loss ratio threshold of 88 per cent, the carrier's base rates shall nevertheless not be presumptively disapproved as excessive by the commissioner if the carrier's aggregate medical loss ratio for all plans offered under this chapter is not less than 1 per cent greater than the carrier's equivalent medical loss ratio was 12-months prior to the carrier's present rate filing.

If the annual aggregate medical loss ratio for all plans offered under this chapter is less than 88 per cent, or less than the medical loss ratio that was not presumptively disapproved by the commissioner for being in excess of 1% of the carrier's prior year base rate, over the applicable 12-month period, the carrier shall refund the excess premium to its eligible individuals and eligible small groups. A carrier shall

communicate within 30 days to all individuals and small groups that were covered under plans during the relevant 12-month period that such individuals and small groups qualify for a refund to be issued under this paragraph, which may take the form of either a refund on the premium for the applicable 12-month period, or if the individual or groups are still covered by the carrier, a credit on the premium for the subsequent 12-month period. The total of all refunds issued shall equal the amount of a carrier's earned premium that exceeds that amount necessary to achieve a medical loss ratio of 88 per cent, calculated using data reported by the carrier as prescribed under regulations promulgated by the commissioner. The commissioner may authorize a waiver or adjustment of this requirement only if it is determined that issuing refunds would result in financial impairment for the carrier.

(e) If a proposed base rate change has been presumptively disapproved:

(1) A carrier shall communicate to all employers and individuals covered under a small group product that the proposed increase has been presumptively disapproved and is subject to a hearing at the division of insurance.

(2) The commissioner shall conduct a public hearing and shall advertise it in newspapers in the cities of Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell, or shall notify such newspapers of the hearing.

(3) The attorney general may intervene in a public hearing or other proceeding under this subsection and may require additional information as the attorney general consider necessary to ensure compliance with this subsection.

The commissioner shall adopt regulations to specify the scheduling of the hearings required pursuant to this section.

(f) If the commissioner disapproves the rate submitted by a carrier the commissioner shall notify the carrier in writing no later than 45 days prior to the proposed effective date of the carrier's rate. The

carrier may submit a request for hearing with the division of insurance within 10 days of such notice of disapproval. The division must schedule a hearing within 15 days of receipt. The commissioner shall issue a written decision within 30 days after the conclusion of the hearing. The carrier may not implement the disapproved rates, or changes at any time unless the commissioner reverses the disapproval after a hearing or unless a court vacates the commissioner's decision.

SECTION 30. Said section 6 of said chapter 176J, as appearing in section 29, is hereby further amended by striking out the figure "88", each time it appears, and inserting in place thereof the following figure:- 90.

SECTION 31. Said section 6 of said chapter 176J is hereby further amended by striking out clause (d), (e), and (f), as appearing in section 29, inserting in place thereof the following 2 subsections:-

(d) If a proposed base rate change has been disapproved:

(1) A carrier shall communicate to all employers and individuals covered under a small group product that the proposed increase has been presumptively disapproved and is subject to a hearing at the division of insurance.

(2) The commissioner shall conduct a public hearing and shall advertise it in newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell, or shall notify such newspapers of the hearing.

(3) The attorney general may intervene in a public hearing or other proceeding under this subsection and may require additional information as the attorney general consider necessary to ensure compliance with this subsection.

(e) If the commissioner disapproves the rate submitted by a carrier the commissioner shall notify the carrier in writing no later than 45 days prior to the proposed effective date of the carrier's rate. The carrier may submit a request for hearing with the division of insurance within 10 days of such notice of

disapproval. The division must schedule a hearing within 15 days of receipt. The commissioner shall issue a written decision within 30 days after the conclusion of the hearing. The carrier may not implement the disapproved rates, or changes at any time unless the commissioner reverses the disapproval after a hearing or unless a court vacates the commissioner's decision.

SECTION 32. Said chapter 176J is hereby amended by adding the following section:-

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 of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses in at least 1 geographic area at least one plan with either a reduced or selective network of providers, or a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider.

The base premium for the reduced or selective network, or tiered network plan shall be at least 12 per cent lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers.

(b) A tiered network plan shall only include variations on member cost-sharing between provider tiers, which are reasonable in relation to the premium charged, as long as the carrier provides adequate access to covered services at lower patient cost sharing levels.

(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall tiered network plan .

(d) The commissioner shall determine network adequacy for a select network plan based on the availability of sufficient network providers in the carrier's select network of providers.

(e) In determining network adequacy under this section the commissioner may consider factors including: the location of providers participating in the plan; employers or members that enroll in the plan; the range of services provided by providers in the plan; and any plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.

(f) Carriers may: (i) reclassify provider tiers; or (ii) determine provider participation in selective and tiered plans no more than once per calendar year; provided, however, that carriers may reclassify providers from a higher cost tier to a lower cost tier or add new providers to its selective and tiered plans at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during the course of an account year, the carrier shall provide affected members of the account with information regarding the plan changes at least 30 days before the changes take effect. Carriers shall provide information on their websites about any tiered or selective plan, including, but not limited to, the providers participating in the plan, the selection criteria for those providers and if applicable, the tier in which each provider is classified.

(g) The division of insurance shall report annually on utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section The report shall include the number of members enrolled by plan type, de-identified aggregate demographic, and geographic information on all members and the average direct premium claims incurred for selective and tiered network plans compared to non-selective and non-tiered plans.

SECTION 33. Said chapter 176J is hereby further amended by striking out section 11, as inserted by section 23, and inserting in place thereof the following section:-

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 of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible

employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses in at least 1 geographic area at least 1 plan with either a reduced or selective network of providers or a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider.

The base premium for the reduced or selective or tiered network plan shall be at least 12 per cent lower than the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers. The savings may be achieved by means including, but not limited to: (i) the exclusion of providers with similar or lower quality based on the standard quality measure set with higher health status adjusted total medical expenses or relative prices, as determined under section 6 of chapter 118G; or (ii) increased member cost-sharing for members who utilize providers for non-emergency services with similar or lower quality based on the standard quality measure set and with higher health status adjusted total medical expenses or relative prices, as determined under section 6 of chapter 118G.

(b) A tiered network plan shall only include variations in member cost-sharing between provider tiers which are reasonable in relation to the premium charged and ensure adequate access to covered services. Carriers shall tier providers based on quality performance as measured by the standard quality measure set and by cost performance as measured by health status adjusted total medical expenses and relative prices. Where applicable quality measures are not available, tiering may be based solely on health status adjusted total medical expenses or relative prices or both.

The commissioner shall promulgate regulations requiring the uniform reporting of tiering information, including, but not limited to requiring, at least 90 days before the proposed effective date of any tiered network plan or any modification in the tiering methodology for any existing tiered network plan, the reporting of a detailed description of the methodology used for tiering providers, including: the

statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a description of how the methodology and resulting tiers will be communicated to each network provider, eligible individuals and small groups; and a description of the appeals process a provider may pursue to challenge the assigned tier level.

(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall network of providers.

(d) The commissioner shall determine network adequacy for a selective network plan based on the availability of sufficient network providers in the carrier's selective network.

(e) In determining network adequacy under this section the commissioner of insurance may take into consideration factors such as the location of providers participating in the plan and employers or members that enroll in the plan, the range of services provided by providers in the plan and plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.

(f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in selective and tiered plans no more than once per calendar year except that carriers may reclassify providers from a higher cost tier to a lower cost tier or add providers to a selective network at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during the course of an account year, the carrier shall provide affected members of the account with information regarding the plan changes at least 30 days before the changes take effect. Carriers shall provide information on their websites about any tiered or selective plan, including but not limited to, the providers participating in the plan, the selection criteria for those providers and where applicable, the tier in which each provider is classified.

(g) The division of insurance shall report annually on utilization trends of eligible employers and eligible individuals enrolled in plans offered under this section. The report shall 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 products.

SECTION 34. Said chapter 176J is hereby further amended by adding the following 2 sections:-

Section 12. (a) The commissioner shall promulgate regulations governing the establishment and oversight of small business group purchasing cooperatives. The regulations shall require: (i) that all state-mandated benefits are required under plans procured by approved small business group purchasing cooperatives; (ii) that all such plans offer its enrollees access to wellness programs which, at a minimum, shall be actuarially similar to wellness programs that may be offered through the commonwealth health insurance connector authority; (iii) that the group purchasing cooperative obtain a commitment from 33 per cent of its covered employees that the employees will enroll in the health management programs that the group purchasing cooperative provides; (iv) that the group purchasing cooperative establish reasonable systems, which shall comply with any applicable sections of the Americans with Disability Act and any other federal requirements, under which enrollees can record their participation in, and group purchasing cooperatives can monitor enrollees' participation in, available health management programs; (v) that denial of coverage due to the health condition, age, race or sex of the employees and dependents of qualified association members in a group purchasing cooperative is prohibited; and (vi) that no eligible qualified association member of a small business group purchasing cooperative may be charged a premium rate higher than what the carrier would charge to a similarly-situated eligible small business that is not a participant in a small business group purchasing cooperative.

(b) The commissioner shall promulgate regulations governing the application and certification process that a proposed small business group purchasing cooperative shall undergo before the commissioner may certify the group purchasing cooperative as a small business group purchasing cooperative approved to operate in accordance with this section; provided, however, that the

commissioner shall certify up to 6 group purchasing cooperatives to operate at any given time; provided further, that the commissioner shall certify any application that meets the requirements of this section up to and until the commissioner has certified 6 group purchasing cooperatives. The commissioner shall limit the number of applications that are approved for each small business group cooperative so that in a given year, the total number of covered lives, for each approved group purchasing cooperative, in the aggregate, shall not exceed 85,0000 covered lives. Notwithstanding the provisions of this section, once the limit on covered lives is reached, the commissioner shall not approve the application of a new group purchasing cooperative until a previously approved group purchasing cooperative disbands or until the commissioner disapproves a group purchasing cooperative's annual renewal for failure to comply with the terms of this section and any regulations promulgated in accordance with this section.

(c) The commissioner shall annually certify that a small business group purchasing cooperative satisfies the requirements of this section. Only a small business group purchasing cooperative that has been certified by the commissioner may procure health care coverage for the benefit of qualified association members.

(d) The commissioner shall review the books and records of a small business group purchasing cooperative and the methodology which it confirms the status of qualified associations.

(e) Health care coverage procured by a small business group purchasing cooperative shall be sold to qualified association members and may be sold through duly licensed agents, the commonwealth health insurance connector authority or brokers.

(f) Member-employers of qualified associations purchasing health coverage within a group purchasing cooperative shall not have more than 50 eligible employees.

(g) The commissioner, in consultation with the division of health care finance and policy and the commonwealth health insurance connector authority, shall report and make recommendations, as necessary, on the cost savings to the qualified association members that participate in small business

group purchasing cooperatives, the impact, if any, on the establishment of small business group purchasing cooperatives to the risk pool and premium costs in the merged market, and whether the authority of the commissioner to certify small business group purchasing cooperatives should be renewed to the house and senate committees on ways and means and the joint committee on health care financing and financial services within 24 months of the first certification of a small business group purchasing cooperative as defined under this section.

Section 13. (a) As a condition of continued offer of small group health, a carrier that, as of the close of a preceding calendar year, has a combined total of at least 5,000 eligible individuals, eligible employees and eligible dependents who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals shall be annually required to file a plan with each group purchasing cooperative for its consideration if a group purchasing cooperative requests such health plan proposals for its next plan year.

(b) Health benefit plans offered by carriers to group purchasing cooperatives shall: (i) include all state-mandated benefits; (ii) apply preexisting condition limitations and waiting periods in the same manner as the carrier applies them to small group products offered outside the group purchasing cooperative; (iii) apply open enrollment periods for individuals in the same manner as the carrier applies them for individuals outside the group purchasing cooperative, provided, however that small business group purchasing cooperatives shall establish rules and open enrollment periods for qualified association members to enter or exit group purchasing cooperatives; (iv) apply continuation of coverage provisions in the same manner as the carrier applies those provisions to small group products offered outside the group purchasing cooperative; (v) apply managed care practices in the same manner as the carrier applies those practices to small group products offered outside the group purchasing cooperative; and (vi) apply rating rules, including rating bands, rating factors and the value of rating factors, in the same manner as the carrier applies those rules to small group products offered outside the group purchasing cooperative;

provided, that such plans may make limited deviations from these rating factors with the prior approval of the commissioner.

(c) Carriers shall comply with a group purchasing cooperative's wellness program's data processing systems to provide information that will enable the group purchasing cooperative to effectively provide guidance to members on targeted wellness programs.

SECTION 35. Section 2 of chapter 176M of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after the word "renewal", in lines 28 and 39, each time it appears, the following words:- , including renewal through the connector,.

SECTION 36. Section 3 of said chapter 176M, as so appearing, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) A carrier shall no longer offer, sell or deliver a health plan to a person to whom it does not have such an obligation under an individual policy, contract or agreement with an employer or through a trust or association; provided, however, that a closed guaranteed issue plan or a closed health plan shall be subject to all the other requirements of this chapter. A carrier shall be obligated to renew a closed guarantee issue health plan and a closed plan. A carrier may discontinue a closed guarantee issue health plan or a closed under regulations promulgated by the commissioner.

SECTION 37. Section 2 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) In establishing the minimum standards, the bureau shall consult and use, where appropriate, standards established by national accreditation organizations. Notwithstanding the foregoing, the bureau shall not be bound by the standards established by such organizations, provided, however, that wherever the bureau promulgates standards different from the national standards, it shall: (1) be subject to chapter

30A; (2) state the reason for such variation; and (3) take into consideration any projected compliance costs for such variation. In order to reduce health care costs and improve access to health care services, the bureau shall establish by regulation as a condition of accreditation that carriers use uniform standards and methodologies for credentialing of providers, including any health care provider type licensed under chapter 112 that provide identical services. The division shall, before adopting regulations under this section, consult with the division of health care finance and policy, the department of public health, the group insurance commission, the Centers for Medicare and Medicaid Services and each carrier. Accreditation by the bureau shall be valid for a period of 24 months.

SECTION 38. Subsection (a) of section 7 of said chapter 176O, as so appearing, is hereby amended by striking out clause (1) and inserting in place thereof the following clause:-

(1) a list of health care providers in the carrier's network, organized by specialty and by location and summarizing on its internet website for each such provider: (i) the method used to compensate or reimburse such provider, including details of measures and compensation percentages tied to any incentive plan or pay for performance provision; (ii) the provider price relativity, as defined in and reported under section 6 of chapter 118G; (iii) the provider’s health status adjusted total medical expenses, as defined in and reported under said section 6 of said chapter 118G; and (iv) current measures of the provider’s quality based on measures from the Standard Quality Measure Set, as defined in the regulations promulgated by the department of public health under section 25P of chapter 111; provided, however, that if any specific providers or type of providers requested by an insured are not available in said network, or are not a covered benefit, such information shall be provided in an easily obtainable manner; provided, further, that the carrier shall prominently promote providers based on quality performance as measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices.

SECTION 39. Said chapter 176O is hereby further amended by inserting after section 9 the following section:-

Section 9A. A carrier shall not enter into an agreement or contract with a health care provider if the agreement or contract contains a provision that:

(a) (i) limits the ability of the carrier to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation; (ii) requires the carrier to place all members of a provider group, whether local practice groups or facilities, in the same tier of a tiered network plan; (iii) requires the carrier to include all members of a provider group, whether local practice groups or facilities, in a select network plan on an all-or-nothing basis; or (iv) requires a provider to participate in a new select network or tiered network plan that the carrier introduces without granting the provider the right to opt-out of the new plan at least 60 days before the new plan is submitted to the commissioner for approval; or

(b) requires or permits the carrier or the health care provider to alter or terminate a contract or agreement, in whole or in part, to affect parity with an agreement or contract with other carriers or health care providers or based on a decision to introduce or modify a select network plan or tiered network plan; or

(c) requires or permits the carrier to make any form of supplemental payment unless each supplemental payment is publicly disclosed to the commissioner as a condition of accreditation, including the amount and purpose of each payment and whether or not each payment is included within the provider's reported relative prices and health status adjusted total medical expenses under section 6 of chapter 118G.

SECTION 40. Said chapter 176O is hereby further amended by adding the following section: -

Section 21. (a) Each carrier shall submit an annual comprehensive financial statement to the division detailing carrier costs from the previous calendar year.

The annual comprehensive financial statement shall include all of the information in this section and shall be itemized, where applicable, by:

(i) market group size, including individual; small groups of 1 to 5, 6 to 10, 11 to 25 and 26 to 50; large groups of 50 to 100, 101 to 500, 501 to 1000 and greater than 1000; and

(ii) line of business, including individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter 175; a hospital service plan issued by a nonprofit hospital service corporation under chapter 176A; a medical service plan issued by a nonprofit hospital service corporation under chapter 176B; a health maintenance contract issued by a health maintenance organization under chapter 176G; insured health benefit plan that includes a preferred provider arrangement issued under chapter 176I; and group health insurance plans issued by the commission under chapter 32A.

The statement shall include, but shall not be limited to, the following information:

(i) direct premiums earned, as defined in chapter 176J; direct claims incurred, as defined in said chapter 176J;

(ii) medical loss ratio;

(iii) number of members;

(iv) number of distinct groups covered;

(v) number of lives covered;

(vii) realized capital gains and losses;

(viii) net income;

(ix) accumulated surplus;

(x) accumulated reserves;

(xi) risk-based capital ratio, based on a formula developed by the National Association of Insurance Commissioners;

(xii) financial administration expenses, including underwriting, auditing, actuarial, financial analysis, treasury and investment expenses;

(xiii) marketing and sales expenses, including advertising, member relations, member enrollment expenses;

(xiv) distributions expenses, including commissions, producers, broker and benefit consultant expenses;

(xv) claims operations expenses, including adjudication, appeals, settlements and expenses associated with paying claims;

(xvi) medical administration expenses, including disease management, utilization review and medical management expenses;

(xvii) network operational expenses, including contracting, hospital and physician relations and medical policy procedures;

(xviii) charitable expenses, including any contributions to tax-exempt foundations and community benefits;

(xix) board, bureau or association fees;

(xx) any miscellaneous expenses described in detail by expense, including an expense not included in (i) to (xix), inclusive;

(xxi) payroll expenses and the number of employees on the carrier's payroll;

(xxii) taxes, if any, paid by the carrier to the federal government or to the commonwealth; and

(xxiii) any other information deemed necessary by the commissioner.

(b)(1) In this subsection, the following words shall have the following meanings:-

"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; or a third party administrator, a pharmacy benefit manager or other similar entity with claims data, eligibility data, provider files and other information relating to health care provided to residents of the commonwealth and health care provided by health care providers in the commonwealth; provided, however, that "carrier" shall include an entity that offers a policy, certificate or contract that provides coverage solely for dental care services or visions care services.

"Self-insured customer", a self-insured group for which a carrier provides administrative services.

"Self-insured group", a self-insured or self-funded employer group health plan.

"Third-party administrator", a person who, on behalf of a health insurer or purchaser of health benefits, receives or collects charges, contributions or premiums for, or adjusts or settles claims on or for residents of the commonwealth.

(2) Any carrier required to report under this section, which provides administrative services to 1 or more self-insured groups shall include, as an appendix to such report, the following information:

(i) the number of the carrier's self-insured customers;

(ii) the aggregate number of members, as defined in section 1 of chapter 176J, in all of the carrier's self-insured customers;

(iii) the aggregate number of lives covered in all of the carrier's self-insured customers;

(iv) the aggregate value of direct premiums earned, as defined in said section 1 of said chapter 176J, for all of the carrier's self-insured customers;

(v) the aggregate value of direct claims incurred, as defined in said section 1 of said chapter 176J, for all of the carrier's self-insured customers;

(vi) the aggregate medical loss ratio, as defined in said section of said chapter 176J, for all of the carrier's self-insured customers;

(vii) net income;

(viii) accumulated surplus;

(ix) accumulated reserves;

(x) the percentage of the carrier's self-insured customers that include each of the benefits mandated for health benefit plans under chapters 175, 176A, 176B and 176G;

(xi) administrative service fees paid by each of the carrier's self-insured customers; and

(xii) any other information deemed necessary by the commissioner.

(c) A carrier who fails to file this report on or before April 1 shall be assessed a late penalty not to exceed $100 per day. The division shall make public all of the information collected under this section. The division shall issue an annual summary report to the joint committee on financial services, the joint committee on health care financing and the house and senate committees on ways and means of the

annual comprehensive financial statements by May 15. The information shall be exchanged with the division of health care finance and policy for use under section 6 of chapter 118G. The division shall, from time to time, require payers to submit the underlying data used in their calculations for audit.

The commissioner may adopt rules to carry out this subsection, including standards and procedures requiring the registration of persons or entities not otherwise licensed or registered by the commissioner, such as third-party administrators, and criteria for the standardized reporting and uniform allocation methodologies among carriers. The division shall, before adopting regulations under this subsection, consult with other agencies of the commonwealth and the federal government and affected carriers to ensure that the reporting requirements imposed under the regulations are not duplicative.

(d) If, in any year, a carrier reports a risk-based capital ratio on a combined entity basis under subsection (a) that exceeds 700 per cent, the division shall hold a public hearing within 60 days. The carrier shall submit testimony on its overall financial condition and the continued need for additional surplus. The carrier shall also submit testimony on how, and in what proportion to the total surplus accumulated, the carrier will dedicate any additional surplus to reducing the cost of health benefit plans or for health care quality improvement, patient safety or health cost containment activities not conducted in previous years. The division shall review such testimony and issue a final report on the results of the hearing.

SECTION 41. Section 1 of chapter 176Q of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out the definition of "Eligible individuals" and inserting in place thereof the following definition:-

"Eligible individual", an individual who is a resident of the commonwealth and who is not seeking individual coverage to replace an employer sponsored health plan for which the individual is eligible and which provides coverage that is at least actuarially equivalent to minimum creditable coverage.

SECTION 42. Section 2 of said chapter 176Q, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) There shall be a board, with duties and powers established by this chapter, which shall govern the connector. The connector board shall consist of 11 members: the secretary for administration and finance, or a designee, who shall serve as chairperson; the director of Medicaid or a designee; the commissioner of insurance or a designee; the executive director of the group insurance commission; 4 members appointed by the governor, 1 of whom shall be a member in good standing of the American Academy of Actuaries, 1 of whom shall be a health economist, 1 of whom shall represent the interests of small businesses and 1 of whom shall be a member of the Massachusetts chapter of the National Association of Health Underwriters ; and 3 members appointed by the attorney general, 1 of whom shall be an employee health benefits plan specialist, 1 of whom shall be a representative of a health consumer organization and 1 of whom shall be a representative of organized labor. No appointee shall be an employee of any licensed carrier authorized to do business in the commonwealth. All appointments shall serve a term of 3 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. The board shall annually elect 1 of its members to serve as vice-chairperson.

SECTION 43. Section 3 of said chapter 176Q, as so appearing, is hereby amended by inserting after the figure “111M”, in line 118, the following words:- ; provided, however, that notwithstanding subsection (d) of section 2, no changes to the regulations defining minimum creditable coverage shall take effect until 90 days after the connector gives notice of the changes to the joint committee on health care finance, the joint committee on public health, the senate and house of representatives committees on ways and means and the clerks of the senate and house of representatives.

SECTION 44. Said chapter 176Q is hereby further amended by inserting after section 7 the following section:-

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

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

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

(2) the eligible small group is eligible for federal health care tax credits under the federal Patient Protection and Affordable Care Act, Pub. L. 111-148 ;

(3) the eligible small group offers an evidence-based, employee wellness program, that meets certain minimum criteria, as determined by the connector board, in collaboration with the department of public health;

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

(c) For eligible small groups participating in the program, the connector shall provide an annual subsidy not to exceed 5 per cent of eligible employer health care costs as calculated by the employer for credit by the federal government under the federal Patient Protection and Affordable Care Act. Aggregate expenditures made by the connector for the subsidy program shall not exceed $15,000,000 in any fiscal year. If the director determines that funds are insufficient to meet the projected costs of enrolling new eligible employers, the director shall impose a cap on enrollment in the program.

(d) The connector shall coordinate with the department of public health to provide technical assistance, including grant-writing assistance, to participating eligible small groups in order to maximize federal grant funding provided under the federal Patient Protection and Affordable Care Act for the establishment of wellness initiatives by small employers.

(e) The connector shall seek to ensure that all necessary applications and filings coordinate with and conform to appropriate federal guidelines in order to minimize administrative burden on participating small groups.

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

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

SECTION 45. Section 8 of said chapter 176Q, as appearing in the 2008 Official Edition, is hereby amended by adding the following sentence: -

The connector shall not utilize any of the data received from the department of revenue for any solicitations or advertising.

SECTION 46. Paragraph (n) of section 5 of chapter 614 of the acts of 1968, as appearing in section 18 of chapter 777 of the acts of 1981, is hereby amended by striking out, in line 2, the words “its administrative” and inserting in place thereof the following words:- fees, administrative.

SECTION 47. Said section 5 of said chapter 614 is hereby further amended by inserting after paragraph (n), as so appearing, the following paragraph:-

(n1/2) to fund the capital reserves authorized under paragraph (g) of section 10 and to fund and administer loans and grant programs for community hospitals and community health centers under paragraph (g) of section 10 and to fund any reimbursement of the commonwealth required by paragraph (g)(xii) of section 10;.

SECTION 48. Section 10 of said chapter 614, as most recently amended by chapter 777 of the acts of 1981, is hereby further amended by adding the following paragraph:-

(g) (i) For the benefit of nonprofit community hospitals and nonprofit community health centers licensed by the department of public health and meeting the definition of a community health center under 114.6 CMR 13.00 as either a community health center or a hospital licensed health center, the authority may create and establish special funds to be known as Community Hospital and Community Health Center Capital Reserve Funds and, to the extent so created, shall pay into each such fund any monies appropriated and made available by the commonwealth for the purposes of such fund, any proceeds from the sale of notes or bonds to the extent provided in the resolution, trust agreement or indenture of the authority authorizing issuance thereof, any other monies or funds of the authority that the authority determines to deposit in the fund and any other monies which may be available to the authority only for the purpose of such fund from any other source or sources. All monies held in the fund, except as hereinafter provided, shall be used solely for the payment of the principal of bonds of the authority which are secured by any such fund as the same mature, which herein shall include becoming payable by sinking fund installment, the purchase of such bonds, the payment of interest on such bonds, or the payment of any redemption premium required to be paid when such bonds are redeemed prior to maturity; provided however, that, monies in a Community Hospital and Community Health Center Capital Reserve Fund shall not be withdrawn therefrom at any time in such amount as would reduce the amount of the fund to less than the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on outstanding bonds which are secured by the fund, except for the purpose of paying the principal of and interest on such bonds maturing and becoming due or for the retirement of such bonds in

accordance with the terms of a contract between the authority and its bondholders and for the payment of which other monies pledged to secure such bonds are not available. Any income or interest earned by, or increment to, a Community Hospital and Community Health Center Capital Reserve Fund due to the investment thereof shall be used by the authority for the purposes of the fund.

(ii) The authority shall not issue bonds which are secured by a Community Hospital and Community Health Center Capital Reserve Fund at any time if the maximum amount of principal and interest maturing or becoming due in a succeeding calendar year on such bonds then to be issued and on all other outstanding bonds of the authority which are secured by a fund will exceed the amount of such Community Hospital and Community Health Center Capital Reserve Fund at the time of issuance unless the authority, at the time of issuance of such bonds, shall deposit in such fund from the proceeds of the bonds so to be issued, or otherwise, an amount which, together with the amount then in the fund, will be not less than the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on such bonds then to be issued and on all other outstanding bonds of the authority which are secured by any such fund.

(iii) To assure the continued operation and solvency of the authority for the carrying out of the public purposes of this act, provision is made in subparagraph (i) for the accumulation in a Community Hospital and Community Health Center Capital Reserve Fund of an amount equal to the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on all outstanding bonds which are secured by any such fund. In order to further assure the maintenance of a Community Hospital and Community Health Center Capital Reserve Fund, there shall be appropriated annually and paid to the authority for deposit in the fund such sum, if any, as shall be certified by the executive director of the authority to the governor as necessary to restore the fund to an amount equal to the maximum amount of principal and interest maturing and becoming due in a succeeding calendar year on the outstanding bonds which are secured by any such fund. The executive director of the authority shall annually, on or before December 1, make and deliver to the governor a certificate stating the

amount, if any, required to restore a Community Hospital and Community Health Center Capital Reserve Fund to the amount aforesaid and the amount so stated, if any, shall be appropriated and paid to the authority during the then current fiscal year of the commonwealth.

(iv) For the purposes of this paragraph, in computing the amount of a Community Hospital and Community Health Center Capital Reserve Fund, securities in which all or a portion of the fund are invested shall be valued at par or, if purchased at less than par, at their cost to the authority unless otherwise provided in the resolution, trust agreement or indenture authorizing the issuance of bonds secured by the fund.

(v) For the purposes of this paragraph, the amount of a letter of credit, insurance contract, surety bond or similar financial undertaking available to be drawn upon and applied to obligations to which money in the Community Hospital and Community Health Center Capital Reserve Fund may be applied shall be counted as money in the fund. For the purposes of this paragraph, in calculating the maximum amount of interest due in the future on variable rate bonds or bonds with respect to which the interest rate is not at the time of calculation determinable, the interest rate shall be calculated at the maximum interest rate on such bonds or such lesser interest rate as shall be certified by the authority as an appropriate proxy for such variable or non-determinable interest rate.

(vi) Bonds secured by a Community Hospital and Community Health Center Capital Reserve Fund shall be issued by the authority solely for the benefit of nonprofit community hospitals and nonprofit community health centers licensed by the department of public health.

(vii) Notwithstanding any provision of this act to the contrary, no loan shall be made by the authority to a nonprofit community hospital or nonprofit community health center from the proceeds of bonds secured by a Community Hospital and Community Health Center Capital Reserve Fund established under this paragraph unless: (a) the project to be financed by the loan has been approved by the secretary of health and human services; and (b) the loan and the issuance and terms of the related bonds have been

approved by the secretary of administration and finance. In connection with any loan to a nonprofit community hospital or nonprofit community health center under this paragraph, the secretary of health and human services and the secretary of administration and finance may enter into an agreement with the authority and the nonprofit community hospital or nonprofit community health center to: (1) require that the nonprofit community hospital or nonprofit community health center provide financial statements or other information relevant to the financial condition of the nonprofit community hospital or nonprofit community health center and its compliance with the terms of the loan; (2) require that the nonprofit community hospital or nonprofit community health center reimburse the commonwealth for any amounts the commonwealth transfers to the fund under subparagraph (iii) to replenish the fund as a result of a loan payment default by the nonprofit community hospital or nonprofit community health center; and (3) require compliance by the nonprofit community hospital or nonprofit community health center or the authority with any other terms and conditions that the secretary of health and human services and the secretary of administration and finance considers appropriate in connection with the loan.

(viii) When the authority notifies the secretary of administration and finance in writing that an institution eligible to use the authority under this paragraph is in default as to the payment of principal or interest on any bonds issued by the authority on behalf of that institution or that the authority has reasonable grounds to believe that the institution will not be able to make a full payment when that payment is due, the secretary of administration and finance shall direct the comptroller to withhold any funds in the comptroller's custody that are due or payable to the institution until the amount of the principal or interest due or anticipated to be due has been paid to the authority or the trustee for the bondholders, or until the authority notifies the secretary of administration and finance that satisfactory arrangements have been made for the payment of the principal and interest. Funds subject to withholding under this subparagraph shall include, but not be limited to, federal and state grants, contracts, allocations and appropriations.

(ix) If the authority further notifies the secretary of administration and finance in writing that no other arrangements are satisfactory, the secretary shall direct the comptroller to make available to the authority without further appropriation any funds withheld from the institution under subparagraph (viii). The authority shall apply the funds to the costs incurred by the institution, including payments required to be made to the authority or trustee for any bondholders of debt service on any bonds issued by the authority for the institution or payments to replenish the Community Hospital and Community Health Center Capital Reserve Fund or required by the terms of any other law or contract to be paid to the holders or owners of bonds issued on behalf of the institution upon failure or default, or upon reasonable expectation of failure or default, of the institution to pay the principal or interest on its bonds when due.

(x) Concurrent with any notice from the authority to the secretary of administration and finance under this paragraph, the authority may notify any other agency, department or authority of state government that exercises regulatory, supervisory or statutory control over the operations of the institution. Upon notification, the agency, department or authority shall immediately undertake reviews to determine what action, if any, that agency, department or authority should undertake to assist in the payment by the institution of the money due or the steps that the agencies of the commonwealth, other than the comptroller or the authority, should take to assure the continued prudent operation of the institution or provision of services to the people served by the institution.

(xi) Notwithstanding any general or special law to the contrary, in the event that a nonprofit community hospital or nonprofit community health center fails to reimburse the commonwealth for any transfers made by the commonwealth to the authority to replenish the Community Hospital and Community Health Center Capital Reserve Fund under subparagraph (iii) within 6 months after any such transfer and as otherwise provided under the terms of the agreement among the nonprofit community hospital or nonprofit community health center, the authority and the commonwealth authorized under subparagraph (vii), the secretary of administration and finance may, in the secretary's sole discretion, direct the comptroller to withhold any funds in the comptroller's custody that are due or payable to the

nonprofit community hospital or nonprofit community health center to cover all or a portion of the amount the nonprofit community hospital or nonprofit community health center has failed to pay to the commonwealth to reimburse the commonwealth for any such transfers. All contracts issued by the group insurance commission, the commonwealth health insurance connector authority and MassHealth to a third party for the purposes of providing health care insurance paid for by the commonwealth shall provide that, at the direction of the secretary of administration and finance, the third party shall withhold payments to a nonprofit community hospital or nonprofit community health center which fails to reimburse the commonwealth under the agreement authorized under subparagraph (vii) and shall transfer the withheld amount to the commonwealth. Any such withheld amounts shall be considered to have been paid to the nonprofit community hospital or nonprofit community health center for all other purposes of law and the nonprofit community hospital or nonprofit community health center shall be considered to have reimbursed the commonwealth for all or a portion of any such transfers to the Community Hospital and Community Health Center Capital Reserve Fund for purposes of the agreement authorized under said subparagraph (vii).

(xii) Notwithstanding any general or special law to the contrary, if the commonwealth has not been fully reimbursed the amount of any transfer made pursuant to this subsection (g) as of the one year anniversary of such transfer, the authority shall pay to the commonwealth an amount equal to that portion of the transfer for which the commonwealth has not yet received reimbursement as of said anniversary. The reimbursement shall be completed under a schedule determined by the secretary of administration and finance. The reimbursement shall not interfere with the obligations of a nonprofit community hospital or nonprofit community health center pursuant to subsection (g) (xi). Funds received by the commonwealth under subsection (g) (xi) which exceed the full reimbursement to the commonwealth from the authority required by this subsection (g) (xii), shall be paid to the authority.

(xiii) For the purposes of this paragraph, a community hospital or community health center shall not include a hospital where the ratio of the number of physician residents-in-training to the number of inpatient beds exceeds 0.25.

SECTION 49. Section 12 of said chapter 614 is hereby amended by striking out the last sentence and inserting in place thereof the following sentence:- Except as otherwise provided in paragraph (g) of section 10, the issuance of revenue bonds under this act shall not directly, indirectly or contingently obligate the commonwealth or any political subdivision thereof to levy or to pledge any form of taxation therefor or to make any appropriation for payment of those bonds.

SECTION 50. Notwithstanding any special or general law to the contrary, the division of insurance, in consultation with the division of health care finance and policy, shall promulgate regulations on or before October 1, 2010 to establish a uniform methodology for calculating and reporting by carriers for the medical loss ratios of health benefit plans under section 6 of chapter 176J, section 21 of chapter 176O and section 6 of chapter 118G of the General Laws. The uniform methodology for calculating and reporting medical loss ratios shall, at a minimum, specify a uniform method for determining whether and to what extent an expenditure shall be considered a medical claims expenditure or an administrative costs expenditure, which shall include, but not be limited to, a determination of which of these classes of expenditures the following expenses fall into: (i) financial administration expenses; (ii) marketing and sales expenses; (iii) distribution expenses; (iv) claims operations expenses; (v) medical administration expenses, such as disease management, care management, utilization review and medical management activities; (vi) network operation expenses; (vii) charitable expenses; (viii) board, bureau or association fees; (ix) state and federal tax expenses, including assessments; (x) payroll expenses; and (xi) other miscellaneous expenses not included in one of the previous categories. The methodology shall conform with applicable federal statutes and regulations to the maximum extent possible. The division shall, before adopting regulations under this section, consult with: the group insurance commission; the Centers for Medicare and Medicaid Services; the national association of insurance commissioners; the attorney

general; representatives from the Massachusetts Association of Health Plans; the Massachusetts Medical Society Alliance, Inc.; the Massachusetts Hospital Association, Inc.; Health Care for All, Inc.; the Blue Cross and Blue Shield of Massachusetts; the Massachusetts Health Information Management Association; the Massachusetts Health Data Consortium; a representative from a small business association; and a representative from a health care consumer group.

SECTION 51. Notwithstanding any special or general law to the contrary, the division of health care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or before October 1, 2010 to establish a uniform methodology for calculating and reporting the health status adjusted total medical expenses, under section 6 of chapter 118G of the General Laws. The uniform methodology shall apply to a uniform list of provider groups and their constituent local practice groups and for each zip code in the commonwealth. The uniform methodology for calculating and reporting total medical expenses under this section shall, at a minimum:

(i) specify a uniform method for calculating total medical expenses based on allowed claims for all categories of medical expenses, including, but not limited to, acute inpatient, hospital outpatient, sub-acute such as skilled nursing and rehabilitation, professional, pharmacy, mental health and behavioral health and substance abuse, home health, durable medical equipment, laboratory, diagnostic imaging and alternative care such as chiropractic and acupuncture claims, incurred under all fully-insured and self-insured plans;

(ii) specify a uniform method for including in the calculation all non-claims related payments to providers, including supplemental payments of any type, such as pay-for-performance, care management payments, infrastructure payments, grants, surplus payments, lump sum settlements, signing bonuses and government payer shortfall payments; infrastructure, medical director and health information technology payments;

(iii) specify a uniform method for adjusting total medical expenses by health status;

(iv) designate the minimum patient membership in a local practice group for individual reporting of total medical expenses by local practice group;

(v) specify a uniform method for reporting total medical expenses in aggregate for all local practice groups that fall below the minimum patient membership; (vi) specify a uniform method for reporting total medical expenses by zip code separately for patient members whose plans require them to select a primary care provider, and patient members whose plans do not require them to select a primary care provider;

(vii) designate and annually update the comprehensive list of provider groups and local practice groups and zip codes for which payers shall report total medical expenses; and

(viii) specify a uniform format for reporting that includes the raw and adjusted health status score and patient membership for each local practice group and zip code.

The division shall from time to time require payers to submit the underlying data used in their calculation of total medical expenses for audit.

SECTION 52. Notwithstanding any special or general law to the contrary, the division of health care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or before October 1, 2010 to establish uniform methodology for calculating and reporting relative prices paid to hospitals, physician groups, other health care providers licensed under chapter 112 of the General Laws, freestanding surgical centers by each private and public health care payer under section 6 of chapter 118G of the General Laws. The uniform methodology for calculating and reporting relative prices under this section shall, at a minimum: (i) specify a method for basing the calculation on a uniform mix of products and services by payer that is case mix neutral; (ii) specify a uniform method for including in the calculation all non-claims related payments to providers, including supplemental payments of any type, such pay-for-performance, care management payments, infrastructure payments, grants, surplus payments, lump sum settlements, signing bonuses, and government payer shortfall payments; (iii) permit

reporting of relative price in the aggregate for all physician groups whose price equals the payer's standard fee schedule rates; and (vi) designate and annually update the comprehensive list of physician groups for which payers shall report relative prices.

SECTION 53. Notwithstanding any special or general law to the contrary, the division of health care finance and policy, in consultation with the division of insurance, shall promulgate regulations on or before October 1, 2010 to establish uniform methodology for calculating and reporting inpatient and outpatient costs, including direct and indirect costs, for all hospitals under section 6 of chapter 118G of the General Laws. The division shall, as necessary and appropriate, promulgate regulations or amendments to its existing regulations to require hospitals to report cost and cost trend information in a uniform manner including, but not limited to, uniform methodologies for reporting the cost and cost trend for categories of direct labor, debt service, depreciation, advertising and marketing, bad debt, stop-loss insurance, malpractice insurance, health information technology, medical management, development, fundraising, research, academic costs, charitable contributions, and operating margins for all commercial business and for all state and federal government business, including but not limited to Medicaid, Medicare, insurance through the group insurance commission and federal Civilian Health and Medical Program of the Uniformed Services. The division shall, before adopting regulations under this section, consult with the group insurance commission, the Centers for Medicare and Medicaid Services, the attorney general and representatives from the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association the Massachusetts Health Data Consortium.

SECTION 54. The department of public health shall promulgate regulations under section 25P of chapter 111 of the General Laws by December 31, 2010 requiring 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."

The department of public health shall convene a statewide advisory committee which shall recommend to the department by November 1, 2010 the Standard Quality Measure Set. The statewide advisory committee shall consist of the commissioner of health care finance and policy or the commissioner's designee, who shall serve as the chair; and up to 8 members, including the executive director of the group insurance commission and the Medicaid director, or the directors designees; and up to 6 representatives of organizations to be appointed by the governor including at least 1 representative from an acute care hospital or hospital association, 1 representative from a provider group or medical association or provider association, 1 representative from a medical group, 1 representative from a private health plan or health plan association, 1 representative from an employer association and 1 representative from a health care consumer group.

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 department of public health any updates to the Standard Quality Measure Set by November 1. For its recommendation beginning in 2011, the committee may solicit for consideration and recommend other nationally recognized quality measures not yet developed or in use as of November 1, 2010, including 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: (i) the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial infarction, congestive heart failure, pneumonia and surgical infection prevention; (ii) the Hospital Consumer Assessment of Healthcare Providers and Systems survey; (iii) the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of the individual measures by medical or provider group; and (iv) the Ambulatory Care Experiences Survey.

SECTION 55. Notwithstanding and special or general law to the contrary, eligible individuals as defined in chapter 176J with existing coverage issued under said chapter 176J that will expire after the end of open enrollment in 2010 established under section 4 of said chapter 176J may renew coverage on the date that the eligible individual's coverage expires for a term of less than 1 year until the beginning of open enrollment period in 2011.

SECTION 56. Notwithstanding any general or special law to the contrary, the secretary of health and human services shall convene an administrative simplification working group consisting of the following members: the secretary of consumer affairs and business regulation or the secretary's designee, the commissioner of health care finance and policy or the commissioner's designee, the commissioner of public health or the commissioner's designee, the commissioner of insurance or the commissioner's designee, the commissioner of revenue or the commissioner's designee, the director of the office of Medicaid or the director's designee, the attorney general or the attorney general's designee, the inspector general or the inspector general's designee, a representative of the Massachusetts Health Data Consortium, a representative of an association of health care providers licensed under chapter 112 who is not a medical doctor, a representative of the Health Care Quality and Cost Council, a representative of the Massachusetts Hospital Association, Inc., a representative of BC/BS of Massachusetts, a representative of the Massachusetts Association of Health Plans, a representative of the Massachusetts Medical Society, and the executive director of the commonwealth health insurance connector authority or the executive director's designee. The group shall identify ways to streamline state created or mandated administrative requirements in health care, including ways to reduce health care reporting requirements through maximizing the use of a single all-payer data base, as administered by the division of health care finance and policy. The group shall hold its first meeting not later than January 1, 2011 and shall issue a report on or before April 1, 2011. The report shall include specific steps to be taken by each agency and the agencies collectively to reduce administrative and filing requirements on health carriers and health care providers, which shall include, but not be limited to, an interagency agreement to use where necessary,

the all-payer claims data base, and to streamline and coordinate all requests for all other data requests from health care providers and health plans in the commonwealth.

SECTION 57. (a) Notwithstanding any special or general law to the contrary, the division of insurance, in consultation with the secretary of health and human services, shall promulgate regulations on or before December 1, 2011 to promote administrative simplification in the processing of claims for health care services under health benefit plans by carriers, as defined in section 1 of chapter 176O of the General Laws. At a minimum, the regulations shall: (1) establish uniform standards and processes for determining health benefit plan member eligibility by health care providers; (2) establish standards and processes for provider appeals of denied claims; and (3) establish a standard authorization form to be submitted by health care providers to obtain authorization to provide health care services to a member. The division shall, before adopting regulations under this section, consult with a statewide advisory commission charged with investigating and studying the relative value of a uniform claims administration system for all payers in the commonwealth.

(b) The commission shall be comprised of: the director of the office of Medicaid or a designee; the commissioner of insurance or a designee; the commissioner of health care finance and policy or a designee; 1 person appointed by the speaker of the house of representatives; 1 person appointed by the senate president; 1 person appointed by the minority leader of the house of representatives; 1 person appointed by the minority leader of the senate; 1 person designated by the Massachusetts Association of Health Plans, Inc.; 1 person designated by Blue Cross Blue Shield of Massachusetts, Inc.; 2 persons designated by the Massachusetts Hospital Association, Inc., 1 of whom shall represent teaching hospitals and 1 of whom shall represent community hospitals; 1 person designated by the Massachusetts Public Health Association; and 2 persons designated by the Massachusetts Medical Society. In addition, the regional administrator of the federal Centers for Medicare & Medicaid Services or a designee, and a member of the senior management of a Medicare administrative contractor will be invited to participate in the commission, but shall not have a vote.

(c) The commission shall undertake a study of the feasibility of mandating a single claims administration system for all payers in the commonwealth, other than Medicare, and of the potential savings to be derived from doing so. For purposes of this section, the term 'payer' shall mean both a private health care payer and a public health care payer, as those terms are defined in section 1 chapter 118G of the General Laws. In undertaking its responsibilities under this section, the commission shall (i) determine the feasibility of using a single claims administration system for all payers in the commonwealth, other than Medicare; (ii) (ii) undertake a detailed analysis of the merits and limits of the Medicare claims administration system; (iii) determine what models exist that might constitute the most efficient and effective consolidated claims administration system; (iv) identify potential challenges associated with implementation of a single claims administration system for all payers in the commonwealth other than Medicare and also identify proposed solutions for such challenges; (v) identify the costs being incurred by payers and providers as a result of multiple claims administration systems; (vi) estimate the potential cost savings to the commonwealth if the Medicaid program were to implement a uniform claims administration system based on Medicare's system, using regional Medicare administrative contractors; (vii) estimate the potential cost savings if all private health care payers in the commonwealth implemented a uniform claims administration system based on Medicare's system, using regional Medicare administrative contractors, including for their Medicare advantage programs; and (viii) determine the potential savings and costs associated with creating incentives or requiring ERISA plans, Taft-Hartley plans and other self-funded health benefit plans to use regional Medicare administrative contractors for claims management.

SECTION 58. Notwithstanding any general or special law to the contrary, there shall be a special commission to make an investigation and study relative to the impact of reducing the number of health benefit plans that a health care payer may maintain and offer to individuals and employers. The commission shall consist of the 13 members including: the commissioner of insurance, who shall serve as chair; the executive director of the commonwealth health insurance connector authority; a representative

of the Massachusetts Hospital Association, the Massachusetts Medicaid Society, the Massachusetts Association of Health Plans, the Blue Cross and Blue Shield of Massachusetts, the Massachusetts Health Information Management Association, the Massachusetts Health Data Consortium, a MassHealth contracted managed care organization, Associated Industries of Massachusetts, a health care consumer group, and the Massachusetts chapter of the National Federation of Independent Business; and a representative of an association of health care providers licensed under chapter 112 of the General Laws who is not a medical doctor. In conducting its analysis, the commission shall examine:

(i) the administrative costs associated with paying claims and submitting claims for multiple health benefit plans on health care payers and providers;

(ii) the costs associated with reducing the number of health benefit plans on consumer and employer choice;

(iii) the impact of limiting the number of health benefit plans on competition between and among insurance payers, including but not limited to, tiered products, limited network products and products with a range of cost sharing options; and

(iv) the potential for disruption to the market resulting from closing a health care payer's existing health benefit plans.

The special commission shall convene not later than October 1, 2010 and shall submit a report to the clerks of the house and senate not later than December 31, 2010.

SECTION 59. Notwithstanding any special or general law to the contrary, in implementing this act, the executive office of health and human services, the department of public health, the division of health care finance and policy, the division of insurance, the group insurance commission and any other relevant governmental entities or commissions may consider the special needs of children and of pediatric patients. In developing or utilizing data standards, quality measurement systems, wellness initiatives or

making comparisons of costs and prices, policymakers shall consider the special needs of children and of pediatric patients and may require that comparative data and reports segregate pediatric patients and providers from adult patients and providers.

SECTION 60. There shall be a special commission to make an investigation and study relative to the capital needs of the community hospital sector with regard to use of technology and adequacy of facilities, the ability of the sector to meet the health care needs of the general population in the next decade and potential sources of capital to meet those needs. The commission shall also evaluate the role of public programs, payments and regulations in supporting capital accumulation and make recommendations to advance the ability of the community hospital sector to meet the expected demand. The commission shall be comprised of the secretary of health and human services, the commissioner of public health, the secretary of administration and finance, a representative of the Massachusetts Council of Community Hospitals, a representative of the Massachusetts Hospital Association, a representative of the Associated Industries of Massachusetts, a representative of the Massachusetts Business Roundtable, the chief executive officer of the Massachusetts health and educational facilities authority, the chief executive officer of the Massachusetts development finance agency, the chairs of the house and senate committees on ways and means, the house and senate chairs of the joint committee on health care financing, a member of the house of representatives who shall be chosen by the minority leader, a member of the senate who shall be chosen by the minority leader, a chief elected local official with a community hospital located in said community who shall be appointed by the governor, an individual knowledgeable about demographic trends and hospital utilization who shall be appointed by the governor and an individual knowledgeable about hospital finance and construction who shall be appointed by the governor.

The commission shall hold hearings and file a report with the clerks of the house and senate not later than December 31, 2011.

SECTION 61. Notwithstanding any general or special law to the contrary, the department of public health shall conduct a study of the commonwealth's community hospitals, with a particular focus on outmigration of patients and related trends, including but not limited to an examination of observed effects and their potential causes with respect to the following:

(i) the impact on individual community hospitals caused by the opening of additional health care services by providers within the primary service areas of such community hospital, in terms of changes in the number and types of procedures performed and changes in revenues;

(ii) recruitment and retention of personnel; and

(iii) changes in payer mix.

The department shall issue a report summarizing its findings and making recommendations with respect to strengthening community hospitals not later than December 31, 2010, and shall file such report with the joint committee on health care financing.

SECTION 62. Notwithstanding any general or special law to the contrary nothing in subsection (c) of section 6C of chapter 118G of the General Laws shall prevent the annual preparation of the public health access program beneficiary employer report under section 304 of chapter 149 of the acts of 2004.

SECTION 63. Notwithstanding the provisions of any general or special law to the contrary, the Division of Medical Assistance shall promulgate regulations on or before January 1, 2011 that are designed to conform the ordering of treatment related urine drug screens with both Chapter 160 of the Acts of 2006 governing independent clinical laboratory services and the Department of Public Health regulations at 105 CMR 164 et. seq. governing the provisions of substance abuse treatment services, by revising its definition of 'authorized prescriber' at 130 CMR 401.402 to separately include, for the purpose of ordering treatment related random urine drug screens, substance abuse treatment programs that are licensed by the Department of Public Health's Bureau of Substance Abuse Services.

SECTION 64. In order to facilitate the provision of cost effective health care services, enhance the quality of care and improve the coordination and efficiency of health care services in the commonwealth, the division of health care finance and policy, herein referred to as the division, shall undertake activities intended to foster the adoption by providers and payers in the commonwealth of arrangements by which providers will contract to accept payment on a bundled, rather than a fee-for-service, basis. To promote provider participation in such bundled payment arrangements, the division shall make technical support available to providers and payers, survey or undertake research concerning existing and proposed bundled payment models within the commonwealth and elsewhere and disseminate the results of such research; assess the effects of federal programs intended to promote use of bundled payment arrangements; and identify sources of funding to support providers in designing and implementing bundled payment initiatives. The division shall have as an objective, but not as a requirement, the implementation of pilot bundled payment programs relating to payment for at least 2 acute conditions or procedures commencing by no later than January 1, 2011, under the terms of which inpatient services, as well as certain services provided pre- and post-inpatient stay, will be paid on a bundled payment basis; and the implementation of pilot bundled payment programs relating to payment for at least 2 chronic conditions commencing by no later than July 1, 2011. The division shall file reports on the efforts it undertakes to provide support for providers and payers to enter into bundled arrangements and on the progress made toward implementing the goals described in the preceding sentence of this section. Such reports shall be filed with the clerks of the senate and the house of representatives and with the governor not later than January 31, 2011, not later than July 29, 2011 and not later than December 30, 2011.

SECTION 65. The division of insurance shall conduct a study to ensure that the carrier reporting deadlines included in subsections (b) and (c) of section 6 of chapter 176J of the General Laws are of the appropriate duration to enable carriers to collect sufficient information with which to ensure the accuracy of proposed plan changes. If the division determines that a reporting date of 90 days prior to the effective

date of plan changes is inappropriate, the division shall determine the appropriate length of time for carriers to report plan changes to the division of insurance and the attorney general and shall make such recommendation to the general court. The study shall be completed by July 31, 2011 and filed with the clerks of the house of representative and senate, the chairs of the joint committee on health care financing and the chairs of the house and senate committee on ways and means.

SECTION 66. For small group base rate factors applied under section 3 of chapter 176J between October 1, 2010 and June 30, 2012, a carrier shall limit the effect of the application of any single or combination of rate adjustment factors identified in paragraphs (2) to (6), inclusive, of subsection (a) of said chapter 3 of said chapter 176J of the General Laws that are used in the calculation of an individual's or small group's premium so that the final annual premium charged to an individual or small group does not increase by more than an amount established annually by the commissioner by regulation.

SECTION 66A. Notwithstanding any general or special law to the contrary, a participating provider, as defined in chapter 176O of the General Laws, may contract with a carrier, as defined in chapter 176J of the General Laws, to provide one-time supplemental funding for the purposes of issuing refunds for all health benefit plans issued to its current eligible individuals and small groups under said chapter 176J. The refund may take the form of either a refund on the premium for the applicable 12-month period or any other form determined by the parties by contract. The division of insurance may require the filing of such contracts after execution for the purposes of ensuring distribution as provided in the contracts. The division shall issue a public report by December 31, 2010 detailing the participating providers who have entered into such contracts in calendar year 2010, the amount of one-time supplemental funding by participating provider, and the estimated aggregate refunds to be provided to eligible individuals and small groups. The commissioner may issue further regulations as necessary to implement this section.

SECTION 67. (a) Notwithstanding any general or special law to the contrary, there shall be a special commission on provider price reform that shall investigate the rising cost of health care insurance and the impact of reimbursement rates paid by health insurers to providers. The commission shall examine policies aimed at enhancing competition, fairness and cost-effectiveness in the health care market though the reduction of reimbursement disparities. Any recommendations shall consider, and be consistent with, the recommendations of the special commission on payment system as authorized in section 44 of chapter 305 of the acts of 2008.

(b) The commission shall consist of the secretary of administration and finance and the commissioner of health care finance and policy, who shall serve as co-chairs, the executive director of the group insurance commission, 1 person to be appointed by the senate president, 1 person to be appointed by the speaker of the house, and 5 members to be appointed by the Governor, 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc., 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc., 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc., 1 of whom shall be a representative of the Massachusetts Medical Society, and 1 of whom shall be a health economist or expert in the area of payment methodology. The commission shall adopt rules and establish procedures it considers necessary for the conduct of its business. The commission may expend funds as may be appropriated or made available for its purposes. No action of the commission shall be considered official unless approved by a majority vote of the commission members.

(c) The commission shall examine: (i) the variation in relative prices paid to providers within similar provider groups; (ii) the variation in costs of providers for services of comparable acuity, quality and complexity; (iii) the variation in volume of care provided at providers with low and high levels of relative prices or health status adjusted total medical expenses; (iv) the correlation between price paid to providers and (1) the quality of care, (2) the acuity of the patient population, (3) the provider's payor mix, (4) the provision of unique services, including specialty teaching services and community services, and

(5) operational costs, including labor costs; (iii) the correlation between price paid to providers and, in the case of hospitals, status as a disproportionate share hospital, a specialty hospital, a pediatric specialty hospital or as an academic teaching hospital; and (v) policies to promote the use of providers with low health status adjusted total medical expenses.

(d) In making its investigation, the commission shall consult with the attorney general, the health care quality and cost council, the division of health care finance and policy, health care economists, and other individuals or organizations with expertise in state and federal health care payment methodologies and reforms. The commission shall use data and recommendations gathered in the course of these consultations as a basis for its findings and recommendations.

(e) The commission shall file a report of its findings and recommendations.

Before a final vote on any recommendations, the commission shall consult with a reasonable variety of parties likely to be affected by its recommendations, including, but not limited to, the office of Medicaid, the division of health care finance and policy, the commonwealth health insurance connector, the Massachusetts Council of Community Hospitals, Inc., the Massachusetts League of Community Health Centers, Inc., 1 or more academic medical centers, 1 or more hospitals with a high proportion of public payors, 1 or more Taft-Hartley plans, 1 or more self-insured plans with membership of more than 500, the Massachusetts Municipal Association, Inc. and organizations representing health care consumers. The commission shall file the report of its findings and recommendations, with the clerks of the senate and the house of representatives and with the governor not later than February 1, 2011.

SECTION 68. Sections 1, 2, 3, 10, 11, 12, 13, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 34, 36, 39, 43, 46, 47, 48, 49, 51, 60, 61, 65, 66 shall take effect on October 1, 2010.

SECTION 69. Section 30 shall take effect on October 1, 2011.

SECTION 70. Section 31 shall take effect on October 1, 2012.

SECTION 71. Sections 14, 35, 41, 62 shall take effect on July 1, 2012.

SECTION 72. Sections 38, 42, 44, 45 shall take effect on July 1, 2011.

SECTION 73. Sections 32, 37, 40 shall take effect on January 1, 2011.

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Acts 2011

CHAPTER 69 AN ACT RELATIVE TO MUNICIPAL HEALTH INSURANCEE.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is immediately to authorize municipalities to implement local health insurance changes, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

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

SECTION 1. Chapter 32B of the General Laws is hereby amended by striking out section 2, as appearing in the 2008 Official Edition, and inserting in place thereof the following section:-

Section 2. As used in this chapter the following words shall, unless the context clearly requires otherwise, have the following meanings:-

“Appropriate public authority”, as to a county, except Worcester county, the county commissioners; as to a city, the mayor; as to a town, the selectmen; as to a district, the governing board of the district and for the purposes of this chapter if a collective bargaining agreement is in place, as to a commonwealth charter school as defined by section 89 of chapter 71, the board of trustees; and as to an education collaborative, as defined by section 4E of chapter 40, the board of directors.

“Commission”, the group insurance commission established by section 3 of chapter 32A.

“Dependent”, an employee’s spouse, an employee’s unmarried children under 19 years of age and any child 19 years of age or over who is mentally or physically incapable of earning the child’s own living; provided, however, that any additional premium which may be required shall be paid for the coverage of such child 19 years of age or over; provided further, that “dependent” shall also include an unmarried child 19 years of age or over who is a full-time student in an educational or vocational institution and whose program of education has not been substantially interrupted by full-time gainful employment, excluding service in the armed forces; provided further, that any additional premium which may be required for the coverage of such student shall be paid in full by the employee. The standards for such full-time instruction and the time required to complete such a program of education shall be determined by the appropriate public authority.

“District”, any water, sewer, light, fire, veterans’ services or other improvement district or public unit created within 1 or more political subdivisions of the commonwealth to provide public services or conveniences.

“Employee”, any person in the service of a governmental unit or whose services are divided between 2 or more governmental units or between a governmental unit and the commonwealth, and who receives compensation for any such service, whether such person is employed, appointed or elected by popular vote, and any employee of a free public library maintained in a city or town to the support of which that city or town annually contributes not less than one-half of the cost; provided, however, that the duties of such person require not less than 20 hours, regularly, in the service of the governmental unit during the regular work week of permanent or temporary employment; provided further, that no seasonal employee or emergency employees shall be included, except that persons elected by popular vote may be considered eligible employees during the entire term for which they are elected regardless of the number of hours devoted to the service of the governmental unit. A member of a call fire department or other volunteer emergency service agency serving a municipality shall be considered an employee, if approved by vote of the municipal legislative body, and the municipality shall charge such individual 100 per cent of the premium. If an employee’s services are divided between governmental units, the employee shall, for the purposes of this chapter, be considered an employee of the governmental unit which pays more than 50 per cent of the employee’s salary. But, if no one governmental units pays more than 50 per cent of that employee’s salary, the governmental unit paying the largest share of the salary shall consider the employee as its own for membership purposes, and that governmental unit shall contribute 50 per cent of the cost of the premium. If the payment of an employee’s salary is equally divided between governmental units, the governmental unit having the largest population shall contribute 50 per cent of the cost of the premium. If an employee’s salary is divided in any manner between a governmental unit and the commonwealth, the governmental unit shall contribute 50 per cent of the cost of the premium. An employee eligible for coverage under this chapter shall not be eligible for coverage as an employee under chapter 32A. Teachers and all other public school employees shall be deemed to be employees during the months of July and August under this chapter; provided, however, that employee contributions for such health insurance for those 2 months are deducted from the compensation paid for services rendered during the previous school year. A determination by the appropriate public authority that a person is eligible for participation in the plan of insurance shall be final. Nothing in this paragraph shall apply to Worcester county or its employees.

“Employer”, the governmental unit.

“Governmental unit”, any political subdivision of the commonwealth.

“Health care flexible spending account”, a federally-recognized tax-exempt health benefit program

that allows an employee to set aside a portion of earnings to pay for qualified expenses as established in an employer's benefit plan.

"Health care organization", an organization for the group practice of medicine, with or without hospital or other medical institutional affiliations, which furnishes to the patient a specified or unlimited range of medical, surgical, dental, hospital and other types of health care services.

"Health reimbursement arrangement", a federally-recognized tax-exempt health benefit program funded solely by an employer to reimburse subscribers for qualified medical expenses.

"Optional Medicare extension", a program of hospital, surgical, medical, dental and other health insurance for such active employees and their dependents and such retired employees and their dependents, except elderly governmental retirees insured under section 11B, as are eligible or insured under the federal health insurance for the aged act, as may be amended from time to time.

"Political subdivision", any county, except Worcester county, city, town or district.

"Savings", for the purposes of sections 21, 22 and 23, shall mean the difference between the total projected premium costs for health insurance benefits provided by a political subdivision with changes made to health insurance benefits under section 22 or 23 for the first 12 months after the implementation of such changes and the total projected premium costs for health insurance benefits provided by that subdivision without such changes for the same 12 month period.
"Subscribers", employees, retirees, surviving spouses and dependents of the political subdivision and may include employees, retirees, surviving spouses and dependents of a district who previously received health insurance benefits through the political subdivision.

SECTION 2. Section 12 of said chapter 32B is hereby amended by adding the following paragraph:-

The board of a trust or joint purchase group established by 2 or more governmental units may vote to implement changes to co-payments, deductibles, tiered provider network copayments and other cost-sharing plan design features which do not exceed those which an appropriate public authority may offer under section 22; provided, however, that each governmental unit that is a member of a trust or group shall comply with the requirements set forth in section 21 before any such changes may be applied to the health insurance coverage of such governmental unit's subscribers. If such changes to the dollar amounts for copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features do not exceed those permitted under section 22, such changes shall be approved in accordance with the provisions of section 21.

SECTION 3. Said chapter 32B is hereby further amended by adding the following 9 sections:-

Section 21. (a) Any political subdivision electing to change health insurance benefits under sections 22 or 23 shall do so in the following manner: in a county, except Worcester county, by a vote of the county commissioners; in a city having Plan D or a Plan E charter, by majority vote of the city council and approval by the manager; in any other city, by majority vote of the city council and approval by the mayor; in a town, by vote of the board of selectmen; in a regional school district, by vote of the regional district school committee; and in all other districts, by vote of the registered voters of the district at a district meeting. This section shall be binding on any political subdivision that implements changes to health insurance benefits pursuant to section 22 or 23.

(b) Prior to implementing any changes authorized under sections 22 or 23, the appropriate public authority shall evaluate its health insurance coverage and determine the savings that may be realized after the first 12 months of implementation of plan design changes or upon transfer of its subscribers to the commission. The appropriate public authority shall then notify its insurance advisory committee, or such committee's regional or district equivalent, of the estimated savings and provide any reports or other documentation with respect to the determination of estimated savings as requested by the insurance advisory committee. After discussion with the insurance advisory committee as to the estimated savings, the appropriate public authority shall give notice to each of its collective bargaining units to which the authority provides health insurance benefits and a retiree representative, hereafter called the public employee committee, of its intention to enter into negotiations to implement changes to health insurance benefits provided by the appropriate public authority. The retiree representative shall be designated by the Retired State, County and Municipal Employees Association. A political subdivision which has previously established a public employee committee under section 19 may implement changes to its health insurance benefits pursuant to this section and sections 22 and 23.
Notice to the collective bargaining units and retirees shall be provided in the same manner as prescribed in section 19. The notice shall detail the proposed changes, the appropriate public authority's analysis and estimate of its anticipated savings from such changes and a proposal to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected.

(c) The appropriate public authority and the public employee committee shall have not more than 30 days from the point at which the public employee committee receives the notice as provided in subsection (b) to negotiate all aspects of the proposal. An agreement with the appropriate public authority shall be approved by a majority vote of the public employee committee; provided, however, that the retiree representative shall have a 10 per cent vote. If after 30 days the appropriate public authority and public employee committee are unable to enter into a written agreement to implement changes under section 22 or 23, the matter shall be submitted to a municipal health insurance review panel. The panel shall be comprised of 3 members, 1 of whom shall be appointed by the

public employee committee, 1 of whom shall be appointed by the public authority and 1 of whom shall be selected through the secretary of administration and finance who shall forward to the appropriate public authority and the public employee committee a list of 3 impartial potential members, each of whom shall have professional experience in dispute mediation and municipal finance or municipal health benefits, from which the appropriate public authority and the public employee committee may jointly select the third member; provided, however, that if the appropriate public authority and the public employee committee cannot agree within 3 business days upon which person to select as the third member of the panel, the secretary of administration and finance shall select the final member of the panel. Any fee or compensation provided to a member for service on the panel shall be shared equally between the public employee committee and the appropriate public authority.

(d) The municipal health insurance review panel shall approve the appropriate public authority's immediate implementation of the proposed changes under section 22; provided, however, that any increases to plan design features have been made in accordance with the provisions of section 22. The municipal health insurance review panel shall approve the appropriate public authority's immediate implementation of the proposed changes under section 23; provided, that the panel confirms that the anticipated savings under those changes would be at least 5 per cent greater than the maximum possible savings under section 22. If the panel does not approve implementation of changes made pursuant to section 22 or section 23, the public authority may submit a new proposal to the public employee committee for consideration and confirmation under this section.

(e) Within 10 days of receiving any proposed changes under sections 22 or 23, the municipal health insurance review panel shall: (i) confirm the appropriate public authority's estimated monetary savings due to the proposed changes under section 22 or 23 and ensure that the savings is substantiated by documentation provided by the appropriate public authority; provided, however, that if the panel determines the savings estimate to be unsubstantiated, the panel may require the public authority to submit a new estimate or provide additional information to substantiate the estimate; (ii) review the proposal submitted by the appropriate public authority to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected; and (iii) concur with the appropriate public authority that the proposal is sufficient to mitigate, moderate or cap the impact of these changes for subscribers, including retirees, low-income subscribers and subscribers with high out-of-pocket health care costs, who would otherwise be disproportionately affected or revise the proposal pursuant to subsection (f).

(f) The municipal health insurance review panel may determine the proposal to be insufficient and may require additional savings to be shared with subscribers, particularly those who would be disproportionately affected by changes made pursuant to sections 22 or 23, including retirees, low-

income subscribers and subscribers with high out-of-pocket costs. In evaluating the distribution of savings to retirees, the panel may consider any discrepancy between the percentage contributed by retirees, surviving spouses and their dependents to plans offered by the public authority as compared to other subscribers. In reaching a decision on the proposal under this subsection, the municipal health insurance review panel may consider an alternative proposal, with supporting documentation, from the public employee committee to mitigate, moderate or cap the impact of these changes for subscribers. The panel may require the appropriate public authority to distribute additional savings to subscribers in the form of health reimbursement arrangements, wellness programs, health care trust funds for emergency medical care or inpatient hospital care, out-of-pocket caps, Medicare Part B reimbursements or reimbursements for other qualified medical expenses; provided, however that in no case shall the municipal health insurance review panel designate more than 25 per cent of the estimated savings to subscribers. The municipal health insurance review panel shall not require a municipality to implement a proposal to mitigate, moderate or cap the impact of changes authorized under section 22 or 23 which has a total multi-year cost that exceeds 25 per cent of the estimated savings. All obligations on behalf of the appropriate public authority related to the proposal shall expire after the initial amount of estimated savings designated by the panel to be distributed to employees and retirees has been expended. The panel shall not impose any change to contribution ratios.

(g) The decision of the municipal health insurance review panel shall be binding upon all parties.

(h) The secretary of administration and finance shall promulgate regulations establishing administrative procedures for the negotiations with the public employee committee and the municipal health insurance review panel, and issue guidelines to be utilized by the appropriate public authority and the municipal health insurance review panel in evaluating which subscribers are disproportionately affected, subscriber income and subscriber out-of-pocket costs associated with health insurance benefits.

Section 22. (a) Upon meeting the requirements of section 21, an appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers by acceptance of any other section of this chapter may include, as part of the health plans that it offers to its subscribers not enrolled in a Medicare plan under section 18A, copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in dollar amount than the copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment; provided, however, that for subscribers enrolled in a Medicare plan pursuant to section 18A the appropriate public authority may include, as part of the health plans that it offers to its subscribers, copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features that are no greater in

dollar amount than the copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment. The appropriate public authority shall not include a plan design feature which seeks to achieve premium savings by offering a health benefit plan with a reduced or selective network or providers unless the appropriate public authority also offers a health benefit plan to all subscribers that does not contain a reduced or selective network of providers.

(b) An appropriate public authority may increase the dollar amounts for copayments, deductibles, tiered provider network copayments and other cost-sharing plan design features; provided that, for subscribers enrolled in a non-Medicare plan, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a non-Medicare plan with the largest subscriber enrollment and, for subscribers enrolled in a Medicare plan under section 18A, such features do not exceed plan design features offered by the commission pursuant to section 4 or 4A of chapter 32A in a Medicare plan with the largest subscriber enrollment; provided, however, that the public authority need only satisfy the requirements of subsection (a) of section 21 the first time changes are implemented pursuant to this section; and provided, further that the public authority meet its obligations under subsections (b) to (h), inclusive, of section 21 each time an increase to a plan design feature is proposed.

Nothing herein shall prohibit an appropriate public authority from including in its health plans higher copayments, deductibles or tiered provider network copayments or other plan design features than those authorized by this section; provided, however, such higher copayments, deductibles, tiered provider network copayments and other plan design features may be included only after the governmental unit has satisfied any bargaining obligations pursuant to section 19 or chapter 150E.

(c) The decision to accept and implement this section shall not be subject to bargaining pursuant to chapter 150E or section 19. Nothing in this section shall preclude the implementation of plan design changes pursuant to this section in communities that have adopted section 19 of this chapter or by the governing board of a joint purchasing group established pursuant to section 12.

(d) Nothing in this section shall relieve an appropriate public authority from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter.

(e) The first time a public authority implements plan design changes under this section or section 23, the public authority shall not increase before July 1, 2014,the percentage contributed by retirees, surviving spouses and their dependents to their health insurance premiums from the percentage that was approved by the public authority prior to and in effect on July 1, 2011; provided however,

that if a public authority approved of an increase in said percentage contributed by retirees before July 1, 2011, but to take effect on a date after July 1, 2011, said percentage increase may take effect upon the approval of the secretary of administration and finance based on documented evidence satisfactory to the secretary that the public authority approved the increase prior to July 1, 2011.

Section 23. (a) Upon meeting the requirements of section 21, an appropriate public authority which has undertaken to provide health insurance coverage to its subscribers may elect to provide health insurance coverage to its subscribers by transferring its subscribers to the commission and shall notify the commission of such transfer. The notice shall be provided to the commission by the appropriate public authority on or before December 1 of each year and the transfer of subscribers to the commission shall take effect on the following July 1. On the effective date of the transfer, the health insurance of all subscribers, including elderly governmental retirees previously governed by section 10B of chapter 32A and retired municipal teachers previously governed by section 12 of chapter 32A, shall be provided through the commission for all purposes and governed under this section. As of the effective date and for the duration of this transfer, subscribers transferred to the commission's health insurance coverage shall receive group health insurance benefits determined exclusively by the commission and the coverage shall not be subject to collective bargaining, except for contribution ratios.

Subscribers transferred to the commission who are eligible or become eligible for Medicare coverage shall transfer to Medicare coverage, as prescribed by the commission. In the event of transfer to Medicare, the political subdivision shall pay any Medicare part B premium penalty assessed by the federal government on retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan. For each subscriber's premium and the political subdivision's share of that premium, the subscriber and the political subdivision shall furnish to the commission, in such form and content as the commission shall prescribe, all information the commission deems necessary to maintain subscribers' and covered dependents' health insurance coverage. The appropriate public authority of the political subdivision shall perform such administrative functions and process such information as the commission deems necessary to maintain those subscribers' health insurance coverage including, but not limited to, family and personnel status changes, and shall report all changes to the commission. In the event that a political subdivision transfers subscribers to the commission under this section, subscribers may be withdrawn from commission coverage at 3 year intervals from the date of transfer of subscribers to the commission.

The appropriate public authority shall provide notice of any withdrawal by October 1 of the year prior to the effective date of withdrawal. All withdrawals shall be effective on July 1 following the political subdivision's notice to the commission and the political subdivision shall abide by all commission

requirements for effectuating such withdrawal, including the notice requirements in this subsection. In the event a political subdivision withdraws from commission coverage under this section, such withdrawal shall be binding on all subscribers, including those subscribers who, prior to the transfer to the commission, received coverage from the commission under sections 10B and 12 of chapter 32A and, after withdrawal from the commission, those subscribers who received coverage from the commission under said sections 10B and 12 of said chapter 32A shall not pay more than 25 per cent of the cost of their health insurance premiums. In the event of withdrawal from the commission, the political subdivision and public employee unions shall return to governance of negotiations of health insurance under chapter 150E and this chapter; provided, however, that the political subdivision may transfer coverage to the commission again after complying with the requirements of subsections (b) to (h), inclusive, of section 21.

The commission shall issue rules and regulations consistent with this section related to the process by which subscribers shall be transferred to the commission.

(b) To the extent authorized under chapter 32A, the commission shall provide group coverage of subscribers' health claims incurred after transfer to the commission. The claim experience of those subscribers shall be maintained by the commission in a single pool and combined with the claim experience of all covered state employees and retirees and their covered dependents, including those subscribers who previously received coverage under sections 10B and 12 of chapter 32A.

(c) A political subdivision that self-insures its group health insurance plan under section 3A and has a deficit in its claims trust fund at the time of transferring its subscribers to the commission and the deficit is attributable to a failure to accrue claims which had been incurred but not paid may capitalize the deficit and amortize the amount over 10 fiscal years in 10 equal amounts or on a schedule providing for a more rapid amortization. Except as provided otherwise herein, subscribers eligible for health insurance coverage pursuant to this section shall be subject to all of the terms, conditions, schedule of benefits and health insurance carriers as employees and dependents as defined by section 2 and commission regulations. The commission shall, exclusively and not subject to collective bargaining under chapter 150E, determine all matters relating to subscribers' group health insurance rights, responsibilities, costs and payments and obligations excluding contribution ratios, including, but not limited to, the manner and method of payment, schedule of benefits, eligibility requirements and choice of health insurance carriers. The commission may issue rules and regulations consistent with this section and shall provide public notice, and notice at the request of the interested parties, of any proposed rules and regulations and provide an opportunity to review and an opportunity to comment on those proposed rules and regulations in writing and at a public hearing; provided, however, that the commission shall not be subject to chapter 30A.

(d) The commission shall negotiate and purchase health insurance coverage for subscribers

transferred under this section and shall promulgate regulations, policies and procedures for coverage of the transferred subscribers. The schedule of benefits available to transferred subscribers shall be determined by the commission pursuant to chapter 32A. The commission shall offer those subscribers the same choice as to health insurance carriers and benefits as those provided to state employees and retirees. The political subdivision's contribution to the cost of health insurance coverage for transferred subscribers shall be as determined under this section, and shall not be subject to the provisions on contributions in said chapter 32A. Any change to the premium contribution ratios shall become effective on July 1 of each year, with notice to the commission of such change not later than January 15 of the same year.

(e) A political subdivision that transfers subscribers to the commission shall pay the commission for all costs of its subscribers' coverage, including administrative expenses and the governmental unit's cost of subscribers' premium. The commission shall determine on a periodic basis the amount of premium which the political subdivision shall pay to the commission. If the political subdivision unit fails to pay all or a portion of these costs according to the timetable determined by the commission, the commission may inform the state treasurer who shall issue a warrant in the manner provided by section 20 of chapter 59 requiring the respective political subdivision to pay into the treasury of the commonwealth as prescribed by the commission the amount of the premium and administrative expenses attributable to the political subdivision. The state treasurer shall recoup any past due costs from the political subdivision's cherry sheet under section 20A of chapter 58 and transfer that money to the commission. If a governmental unit fails to pay to the commission the costs of coverage for more than 90 days and the cherry sheet provides an inadequate source of payment, the commission may, at its discretion, cancel the coverage of subscribers of the political subdivision. If the cancellation of coverage is for nonpayment, the political subdivision shall provide all subscribers health insurance coverage under plans which are the actuarial equivalent of plans offered by the commission in the preceding year until there is an agreement with the public employee committee providing for replacement coverage.

The commission may charge the political subdivision an administrative fee, which shall not be more than 1 per cent of the cost of total premiums for the political subdivision, to be determined by the commission which shall be considered as part of the cost of coverage to determine the contributions of the political subdivision and its employees to the cost of health insurance coverage by the commission.

(f) If there is a withdrawal from the commission under this section, all retirees, their spouses and dependents insured or eligible to be insured by the political subdivision, if enrolled in Medicare part A at no cost to the retiree, spouse or dependents, shall be required to be insured by a Medicare extension plan offered by the political subdivision under section 11C or section 16. A retiree shall provide the political subdivision, in such form as the political subdivision shall prescribe, such

information as is necessary to transfer to a Medicare extension plan. If a retiree does not submit the information required, the retiree shall no longer be eligible for the retiree's existing health insurance coverage. The political subdivision may from time to time request from a retiree, a retiree's spouse and dependents, proof certified by the federal government of the retiree's eligibility or ineligibility for Medicare part A and part B coverage. The political subdivision shall pay the Medicare part B premium penalty assessed by the federal government on those retirees, spouses and dependents as a result of enrollment in Medicare part B at the time of transfer into the Medicare health benefits supplement plan.

(g) The decision to implement this section shall not be subject to collective bargaining pursuant to chapter 150E or section 19.

(h) Nothing in this section shall relieve a political subdivision from providing health insurance coverage to a subscriber to whom it has an obligation to provide coverage under any other provision of this chapter or change eligibility standards for health insurance under the definition of "employee" in section 2.

Section 24. An appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter may provide health care flexible spending accounts to allow certain subscribers, as determined by the appropriate public authority, to set aside a portion of earnings to pay for qualified expenses which may include, but shall not be limited to, out-of-pocket costs such as inpatient and outpatient copayments, calendar year deductibles, office visit copayments and prescription drug copayments.

Section 25. Notwithstanding any general or special law or regulation to the contrary, the appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter or transfer its subscribers to the commission under this chapter may provide health reimbursement arrangements to reimburse subscribers for qualified medical expenses which may include, but shall not be limited to, out-of-pocket costs such as inpatient and outpatient copayments, calendar year deductibles, office visit copayments and prescription drug copayments.

Section 26. An appropriate public authority of a political subdivision which has undertaken to provide health insurance coverage to its subscribers under this chapter shall conduct an enrollment audit not less than once every 2 years. The audit shall be completed in order to ensure that members are appropriately eligible for coverage.

Section 27. An insurance carrier, third party purchasing group or administrator or the commission in the case of a governmental unit, which has undertaken to provide health insurance coverage to its

subscribers by acceptance of sections 19 or 23, shall, upon written request, provide the governmental unit or public employee committee with its historical claims data within 45 days of such request; provided, that all personally identifying information within such claims shall be redacted and released in a form and manner compliant with all applicable state and federal privacy statutes and regulations including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996.

Section 28. Nothing in section 21, 22 or 23 shall be construed to prevent 2 or more governmental units under a joint purchase or trust agreement from jointly negotiating and purchasing coverage as authorized in section 12.

Section 29. Each fiscal year, the commission shall prepare and place on its website a report delineating the dollar amount of the copayments, deductibles, tiered provider network co-payments and other design features offered by the commission in the non-Medicare plan with the largest subscriber enrollment and the dollar amount of the copayments, deductibles, tiered provider network copayments and other design features offered by the commission in the Medicare extension plan with the largest subscriber enrollment. The commission shall also provide information on its plans with the largest subscriber enrollment upon request of any appropriate public authority or political subdivision.

SECTION 4. Notwithstanding any general or special law to the contrary, an appropriate public authority that implements changes to health insurance benefits pursuant to sections 22 and 23 of chapter 32B of the General Laws shall delay implementation of such changes, as to those subscribers covered by a collective bargaining agreement or section 19 agreement that is in effect on the date of implementation of such changes, of any changes to the dollar amounts of copayments, deductibles or other cost-sharing plan design features that are inconsistent with any dollar limits on copayments, deductibles or other cost-sharing plan design features that are specifically included in the body of that collective bargaining agreement or section 19 agreement, until the initial term stated in that collective bargaining agreement or section 19 agreement has ended.

SECTION 5. Nothing in this act shall be construed to alter, amend or affect chapter 36 of the acts of 1998, chapter 423 of the acts of 2002, chapter 27 of the acts of 2003 or chapter 247 of the acts of 2004.

SECTION 6. Notwithstanding any general or special law to the contrary, the group insurance commission shall prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before January 1, 2012, if such political subdivision provides notice to the group insurance commission on or before

September 1, 2011, that it is transferring its subscribers to the group insurance commission under sections 19 or 23 of chapter 32B of the General Laws; provided further, the commission shall also prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before April 1, 2012, if such political subdivision provides notice to the group insurance commission on or before December 1, 2011, that it is transferring its subscribers to the group insurance commission under said sections 19 or 23 of said chapter 32B; provided further, the commission shall also prescribe procedures to permit a political subdivision to transfer all subscribers for whom it provides health insurance coverage to the commission on or before July 1, 2012, if such political subdivision provides notice to the group insurance commission on or before March 1, 2012, that it is transferring its subscribers to the group insurance commission under said sections 19 or 23 of said chapter 32B.

SECTION 7. Notwithstanding any general or special law to the contrary, unless otherwise agreed, a governmental unit transferring its subscribers to the group insurance commission under section 23 of chapter 32B of the General Laws shall use current contribution ratios in existence for each class of plan for each collective bargaining unit in order to transfer to the commission. If a governmental unit was not offering both a preferred provider organization plan or an indemnity plan on the date of transfer to the commission, the governmental unit's initial contribution ratio toward the commission's preferred provider organization plans and indemnity plans shall be the ratio that the governmental unit was contributing toward its preferred provider organization plan or indemnity plan for each collective bargaining unit on that date. Except as specifically provided in this section, all contribution ratios shall remain subject to bargaining pursuant to chapter 32B of the General Laws and chapter 150E of the General Laws.

Approved, July 12, 2011.

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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).

RICHARD T. MOORE
ANTHONY PETRUCCELLI
BRUCE E. TARR

STEVEN M. WALSH
RONALD MARIANO
F. JAY BARROWS

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:

SECTION 1. Section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 25, 29, 32, 37, 39, 48 and 49, 54 and 55, and 86, the words "division of health care finance and policy" and inserting in place thereof, in each instance, the following words:- center for health information and analysis.

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

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

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

SECTION 4. Section 105 of chapter 6 of the General Laws is hereby amended by striking out, in lines 11 and 12, as so appearing, 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 5. Section 16 of chapter 6A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 52, the words “pursuant to section 2A of chapter 118G” and inserting in place thereof the following words:— under section 13C of chapter 118E.

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

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

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

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

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.

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

"Accountable care organization" or "ACO", a provider organization certified under section 15.

"ACO participant", a health care provider that either integrates or contracts with an ACO to provide services to ACO patients.

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

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

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

"Alternative payment contract", any contract between a provider or provider organization and a health care payer payer which utilizes alternative payment methodologies.

"Alternative payment methodologies or methods", methods of payment that are not solely based on fee-for-service reimbursements; provided that, "alternative payment methodologies" may include, but shall not be limited to, shared savings arrangement, bundled payments and global payments; provided further, that "alternative payment methodologies" may include fee-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.

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

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

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

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

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

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

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

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

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

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

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

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

"Medicare program", the medical insurance program established by Title XVIII of the Federal Social Security Act.

"Net cost of private health insurance", the difference between health premiums earned and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as 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.

"Physician", a medical or osteopathic doctor licensed to practice medicine in the commonwealth.

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

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

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

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

"Provider organization", any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not that represents 1 or more health care providers in contracting with carriers for the payments of heath 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

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

"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.

"Secretary", the secretary of health and human services.

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

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

"Self-insured group", a self-insured or self-funded employer group health plan.

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

"State institution", any hospital, sanatorium, infirmary, clinic and other such facility owned, operated or administered by the commonwealth, which furnishes general health supplies, 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 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, 1shall have demonstrated expertise in health care consumer advocacy and shall be initially

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

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

(d) Any action of the commission may take effect immediately and need not be published or posted unless otherwise provided by law. Meetings of the commission shall be subject to sections 18 to 25, inclusive, of chapter 30A; provided however that said sections shall not apply to any meeting of members of the commission serving ex officio in the exercise of their duties as 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

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

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

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

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

(ii) employ professional and clerical staff as necessary;

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

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

(v) undertake any other activities necessary to implement the powers and duties underthis chapter.

The board may approve the use of funds from the Healthcare Payment Reform Fund to support the annual budget of the commission, in addition to funds from any other sourceand any 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'sreceipt 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 excutive director considers appropriate to fulfill the purposes under this chapter,.

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

Section 3. For the purposes ofthis 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

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

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

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

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

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

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

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

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

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

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

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

business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974; 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 underthis 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 ½ 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 TransformationTrust 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 itsintention 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 ther 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

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

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

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

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

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

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

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

(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.

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

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

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

(o) Upon the successful completion of the performance improvement plan, the identity of 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) The commission shall develop and distribute a directory of key existing referral 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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(16) any other requirements the commission considers necessary.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Center for Health Information and Analysis

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

"Accountable care organization", or "ACO", a provider organization certified under section 15 of chapter 6D.

"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 in accordance with generally accepted accounting principles.

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

"Alternative payment contract", any contract between a provider or provider organization and a public health care payer or a private health care payer which utilizes alternative payment methodologies.

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

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

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

"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, but not including 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 vision care services.

"Case mix", the description and categorization of a hospital's patient population according to criteria approved by the center including, but not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

"Center", the center for health information and analysis.

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

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

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

"Commission", the health policy commission established in chapter 6D.

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

"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.

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

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

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

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

"Executive director", the executive director of the center.

"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.

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

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

"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.

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

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

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

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

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

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

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

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

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

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

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

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

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

"Medical service corporation", a corporation established to operate a nonprofit medical service plan as provided in chapter 176B.

"Medicare program", the medical insurance program established by Title XVIII of the Social Security Act.

"Net cost of private health insurance", the difference between health premiums earned and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as 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 promulgate by the center.

"Network contract", a contract entered between a provider or provider organization and a carrier or third-party administrator concerning payment for the provision of heath care services.

"Non-acute hospital", any hospital which is not an acute hospital.

"Patient", any natural person receiving health care services.

"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.

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

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

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

"Provider organization", any corporation, partnership, business trust, association or organized group of persons, which is in the business of health care delivery or management, whether incorporated or not that represents 1 or more health care providers in contracting with carriers for the payments of heath care services,includingbut not 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 the provisions of 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.

"Purchaser", a natural person responsible for payment for health care services rendered by a hospital.

"Quality measures", the standard quality measure set as defined by the center in section 14.

"Registered provider organization," a provider organization that has been registered in accordance with section 11 of chapter 6D.

"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 9 and regulations promulgated by the center.

"Revenue center", a functioning unit of a hospital which provides distinctive services to a patient for a charge.

"Resident", a person living in the commonwealth, as defined by the center 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 chapter; and provided, further that confinement of a person in a nursing home, hospital or other medical institution shall not, in and of itself, suffice to qualify such person as a resident.

"Secretary", the secretary of health and human services.

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

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

"Self-insured group", a self-insured or self-funded employer group health plan.

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

"State institution", any hospital, sanatorium, infirmary, clinic and other such facility owned, operated or administered by the commonwealth, which furnishes general health supplies, 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.

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

"Title XIX", Title XIX of the Social Security Act, 42 USC 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; (ii) all patient cost-sharing amounts, such as deductibles and copayments; and (iii) the net cost of private health insurance, or as otherwise defined in regulations promulgated by the center.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) to enter into agreements or transactions with any federal, state or municipal agency or other public institution or with any private individual, partnership, firm, corporation, association 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 ½ 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums; (2) average annual per-member per-month payments for enrollees in MassHealth primary care clinician and fee for service programs; (3) summaries of plan and network designs for each plan or program, 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 or program; (5) where appropriate, information concerning the payer's current level of reserves and surpluses; (6) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid; (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; and (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 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; () 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.

(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

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

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

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

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

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

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

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

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

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

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

"Adverse event", injury to a patient resulting from a medical intervention and not to the underlying condition of the patient.

"Board", the patient safety and medical errors reduction board.

"Lehman center", the Betsy Lehman center for patient safety and medical error reduction.

"Incident", an incident which, if left undetected or uncorrected, might have resulted in an adverse event.

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

"Patient safety", freedom from accidental injury.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 24. Section 2OOO of chapter 29 of the General Laws, as so appearing, is hereby amended by striking out, in line 6, the words “18B of chapter 118G” and inserting in place thereof the following words:- 18 of chapter 176Q.

SECTION 25. Said section 2OOO of said chapter 29, as so appearing, is hereby further amended by striking out, in line 16, the words “established by section 18 of chapter 118G”.

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

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

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

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

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

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

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

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

(2) The primary care residency grant program, established under section 25N ½ of chapter 111;

(3) a primary care workforce development and loan forgiveness grant program at community health centers, established under section 25N ¾ of chapter 111.

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

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

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

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

(2) address critical health care workforce shortages;

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

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

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

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

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

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

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

(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; and

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

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

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

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

(h) The fund shall supplement and not replace existing publically-financed health care 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

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

(b) 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.

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

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

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

(e) A grant proposal submitted under subsection (d) shall include, but not be limited to: (1) a plan that defines specific goals for improving the efficiency and affordability of hospital care 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) a plan for sustaining any investments after the expiration of grant funds; and (5) any other private funding or private sector participation the applicant anticipates in support of the proposal.

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

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

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

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

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

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

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

administrative costs of the commission; (3) an itemized list of the funds expended through the competitive grant process 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 chairpersons 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.

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

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

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

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

"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.

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

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

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

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

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

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

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

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

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

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

Section 27. The commission shall require any carriers or third party administrators with whom it contracts to provide a toll-free telephone number and website that enables consumers to request and obtain from the carrier or third party administrator, 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 or third party administrator 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 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

All grants shall be recommended by the institute director and subsequently approved by the executive director. The institute director shall work with implementation organizations to oversee the grant-making process as it relates to an implementing organization's responsibilities under its contract with the corporation. Each recipient of monies from this program shall: (i) capture and report certain quality improvement data, as determined by the institute in consultation with the department of public health and the center for health information and analysis; (ii) fully implement an electronic health record system, including all clinical features, 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, positon 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).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) 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.

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

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

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

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

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

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

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

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

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

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

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

The board shall consist of: the commissioner of public health or a designee, who shall serve as chairperson; the executive director of the institute of health care finance and policy established in chapter 12C or a designee; the secretary of health and human services or a designee; and 14 persons to 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 of fewer 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 administer an employee assistance program; 1 of whom shall be a public health nurse or a school nurse; and 1 of whom shall be a person from an association representing community health workers.

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

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

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

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

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

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

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

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

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

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

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

SECTION 70. Said section 25B of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 120 to121, the words “A new technology or innovate” and inserting in place thereof the following words:- a new technology or innovative.

SECTION 71. Said chapter 111 is hereby amended by striking out section 25C and 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 25N ¾ . There shall be established a primary care workforce development and loan forgiveness grant program at community health centers, for the purpose of enhancing recruitment and retention of primary care physicians and other clinicians at community health centers throughout the commonwealth. The grant program shall be administered by the department of public health; provided, that the department may contract with an organization to administer the grant program. Funds may be matched by other public and private funds.

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

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

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

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

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

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

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

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

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

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

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

"Adverse event", injury to a patient resulting from a medical intervention and not from the underlying condition of the patient.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 86. Section 69H of said chapter 111, 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:- executive office of health and human services or a governmental unit designated by the executive office.

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

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

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

SECTION 89. Section 72Q of said chapter 111, 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 90. Section 72Y of said chapter 111, as so appearing, is hereby amended by striking out, in lines 43 and 47, the words “7 of chapter 118G” and inserting in place thereof, in each instance, the following words:- 13D of chapter 118E.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Anatomic pathology service", histopathology, surgical pathology, cytopathology, hematology, subcellular pathology, molecular pathology and blood-banking services performed by a pathologist.

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

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

(i) fluids;

(ii) aspirates;

(iii) washings;

(iv) brushings; or

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

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

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

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

"Patient", any natural person receiving health care services.

"Revenue center", a functioning unit of a hospital which provides distinctive services to a patient for a charge.

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

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

(i) the patient directly;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Terminal illness or condition", an illness or condition which can reasonably be expected 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.

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

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

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

As used in this section, "allowed amount", shall mean the contractually agreed upon 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:-

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

SECTION 110. Section 9C of said chapter 112, as appearing in the 2010 Official Edition, is hereby amended by striking out the definition of "Physician assistant" and inserting in place thereof the following definition:-

"Physician assistant," a person who is duly registered and licensed by the board.

SECTION 111. The first paragraph of section 9E of said chapter 112 , as so appearing, is hereby amended by striking out the last sentence.

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

SECTION 113. Said chapter 112 is hereby further amended by inserting after section 80H the following section:—

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

SECTION 114. Section 8 of chapter 118E of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after clause e the following paragraph:-

e1/2. “Primary care provider”, a health care professional qualified to provide general medical 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 115. Said chapter 118E is hereby amended by inserting after section 8 the following section:—

Section 8A. For the purposes of sections 13C to 13K, inclusive, and sections 64 to 70, inclusive, the following terms and phrases 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 in accordance with generally accepted accounting principles.

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

“Case mix”, the description and categorization of a hospital’s patient population according to criteria approved by the center for health information and analysis including, but

not limited to, primary and secondary diagnoses, primary and secondary procedures, illness severity, patient age and source of payment.

"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 Section 330 of United States Public Law 95-626 and shall include all community health centers which file cost reports as requested by the center.

"Comprehensive cancer center", the hospital of any institution so designated by the national cancer institute organized solely for the treatment of cancer, and offered exemption from the Medicare diagnosis related group payment system.

"Disproportionate share hospital", an 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 payers and free care.

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

"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; provided, that "employee" shall not include a person who is self-employed.

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

"Enrollee", a person who becomes a member of an insurance program of the division either individually or as a member of a family.

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

"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 care, in whole or in part, under applicable regulations of the executive office: (i) services provided by acute hospitals; (ii) services provided by community health centers; and (iii) 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 executive office.

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

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

"Governmental unit", the commonwealth, any department, agency board, commission or poltical subdivision of the commonwealth.

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

"Health care services", supplies, care and services of a medical, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital

care and services, services provided by a community health center or by a sanatorium, included in the definition of "hospital" in Title XVIII of the federal Social Security Act and treatment and care compatible with such services or by a health maintenance organization.

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

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

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

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

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

"Medically necessary services", medically necessary inpatient and outpatient services as mandated under Title XIX of the federal Social Security Act. Medically necessary services shall not include: (i) non-medical services, such as social, educational and vocational services; (ii)

cosmetic surgery; (iii) canceled or missed appointments; (iv) telephone conversations and consultations; (v) court testimony; (vi) 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 (vii) providing whole blood; provided, however, that administrative and processing costs associated with providing blood and its derivatives shall be payable.

"Medicare program", the medical insurance program established by Title XVIII of the federal Social Security Act.

"Non-acute hospital", a hospital which is not an acute hospital.

"Patient", a natural person receiving health care services from a hospital.

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

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

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

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

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

“Resident”, a person living in the commonwealth, as defined by the executive office through a 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 chapter; and provided, further that confinement of a person in a nursing home, hospital or other medical institution shall not in and of itself, suffice to qualify such person as a resident.

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

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

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

“Social service program”, a social, mental health, developmental disabilities, habilitative, rehabilitative, substance abuse, residential care, adult or adolescent day care, vocational, employment and training or elder service program or accommodations purchased by a governmental unit or political subdivision of the executive office of health and human services, but excluding any program, service or accommodation that: (i) is reimbursable under a Medicaid

waiver granted under section 1115 of Title XI of the federal Social Security Act; or (ii) is funded exclusively by a federal grant.

"Social service program provider", a provider of social service programs in the commonwealth.

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

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

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

"Third party payer", an entity including, but not limited to, Title XVIII and Title XIX programs, other governmental payers, insurance companies, health maintenance organizations and nonprofit hospital service corporations; provided, however, that "third party payer" shall not

include a purchaser responsible for payment for health care services rendered by a hospital, either to the purchaser or to the hospital.

SECTION 116. Section 9C of said chapter 118E, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 145, the words “established by subsection (c) of section 18 of chapter 118G”.

SECTION 117. Saidn chapter 118E is hereby further amended by inserting after section 9E the following section:-

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

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

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

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

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

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

(3) monitor the appropriate provision and functional outcomes of community long-term care services, according to the service plan as deemed appropriate by the member and the care team; and track member satisfaction and the appropriate provision and functional outcomes of community long-term care services, according to the service plan as deemed appropriate by the member and the care team.

(c) The ICO or successor organization shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. Providers of institutional or community based long-term services and supports on a compensated basis shall not function as an independent care coordinator; provided, however, that the secretary may grant a waiver of this restriction upon a finding that public necessity and convenience require such a waiver. For the purposes of this section, an organization compensated to provide only evaluation,

assessment, coordination, skills training, peer supports and fiscal intermediary services shall not be considered a provider of long term services and supports.

SECTION 118. Section 12 of said chapter 118E, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 11 and 12, the words “division of health care finance and policy” and inserting in place thereof the following words:- center for health information and analysis.

SECTION 119. Section 13 of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 3 and 4, the words “division of health care finance and policy established by chapter one hundred and eighteen G, which shall be called the “division” only for the purposes of this section and inserting in place thereof the following words:- executive office of health and human services, which shall be called the “executive office” only for the purposes of this section or by a governmental unit designated by the executive office.

SECTION 120. Said section 13 of said chapter 118E, as so appearing, is hereby further amended by striking out, in lines, 9, 15, 18, 20, 22 and 33 the word “division” and inserting in place thereof, in each instance, the following words:- executive office.

SECTION 121. Said section 13 of said chapter 118E, as so appearing, is hereby further amended by striking out, in line 25, the word “division” and inserting in place thereof the following words:- center for health information and analysis.

SECTION 122. Section 13B of said chapter 118E, as so appearing, is hereby further amended by striking out, in lines 11 and 12, the words “the Massachusetts health care quality and cost council, established under section 16K of chapter 6A and”.

SECTION 123. Said chapter 118E is hereby amended by inserting after section 13B the following 10 sections:-

Section 13C. The secretary of the executive office shall establish rates of payment for health care services; provided, that the secretary may designate another governmental unit to perform such ratemaking functions. The secretary of the executive office shall have the responsibility for establishing rates to be paid to providers for health care services by governmental units, including the division of industrial accidents. The rates shall be adequate to meet the costs incurred by efficiently and economically operated facilities providing care and services in conformity with applicable state and federal laws and regulations and quality and safety standards and which are within the financial capacity of the commonwealth. Notwithstanding any general or special law or rule or regulation to the contrary, the secretary of the executive office shall have the responsibility for establishing fair and adequate charges to be used by state institutions for general health supplies, care and rehabilitative services and accommodations, which charges shall be based on the actual costs of the state institution reasonably related, in the circumstances of each institution, to the efficient production of the services in the institution and shall also have sole responsibility for determining rates paid for educational assessments conducted or performed by psychologists and trained, certified educational personnel under the tenth paragraph of section 3 of chapter 71B.

The secretary of the executive office shall have the responsibility for establishing rates of payment for social service programs which are reasonable and adequate to meet the costs which are incurred by efficiently and economically operated social service program providers in providing social service programs in conformity with federal and state law, regulations and 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

administrative costs associated with the use of management companies; the availability of discounts for large volume purchasers; the revision of existing historical cost bases, where applicable, to reflect norms or models of efficient service delivery; and other means to encourage the cost-efficient delivery of services. Rates produced using these methods and standards shall be in conformance with Title XIX, including the upper limit on provider payments.

In determining rates to be paid by governmental units to providers of services, the executive office shall include as an operating expense of a provider of services any contribution made in lieu of taxes by such provider of services to a city or town and shall establish by regulation those expenses treated as business deductions under the Internal Revenue Code, which shall be included as allowable operating expenses in determining rates of reimbursement. Except for ceilings or maximum rates of reimbursement, which are determined in accordance with rate determination methods imposed on nursing homes, any ceiling or maximum imposed by the executive office upon the rate of reimbursement to be paid to rest homes shall reflect the actual costs of rest home providers and shall not prevent any such rest home provider from receiving full payment for costs necessarily incurred in the provision of services in compliance with federal or state regulations and requirements.

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

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

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

In establishing rates for nursing pools under section 72Y of chapter 111, the executive office shall establish annually the limit for the rate for service provided by nursing pools to licensed facilities. The executive office shall establish industry-wide class rates for such services and shall establish separate class rates for services provided to nursing facilities and hospitals. The executive office shall establish separate rates for registered nurses, licensed practical nurses and certified nursing assistants. The executive office may establish rates by geographic region. The rates shall include an allowance for wages, payroll taxes and fringe benefits, which shall be based upon, and shall not exceed, median wages, payroll taxes and fringe benefits paid to permanent medical personnel of the same type at health care facilities in the same geographic region. The rates shall also include an allowance for reasonable administrative expenses and a reasonable profit factor, as determined by the executive office. The executive office may exempt from the rates certain categories, as defined by the executive office, of fixed-term employees that work exclusively at a particular health care facility for a period of at least 90 days and for whose

services there is a contract between a facility and a nursing pool registered with the department of public health. The executive office shall establish procedures by which nursing pools shall submit cost reports, which may be subject to audit, to the executive office to establish rates. The executive office shall determine the nursing pool rate contained in this paragraph by considering wage and benefit data collected from cost reports received from nursing pools and from health care facilities and other relevant information gathered through other collection tools or reasonable methodologies.

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

The executive office may enter into such contracts or agreements with the federal government, a political subdivision of the commonwealth or any public or private corporation or organization, as it deems necessary; provided, however, that the executive office shall not enter into any contract or agreement with a private corporation or organization to furnish information and statistical data to be used by said executive office as its sole basis for setting rates, if such private corporation or organization is to make or receive payments based upon the rates so set.

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

Each rate established by the executive office shall be a regulation and shall be subject to review as hereinafter provided. The executive office shall promulgate rules and regulations for

the administration of its duties and the determination of rates as are herein required subject to the procedures prescribed by chapter 30A. Every rate, classification and other regulation established by the executive office shall be consistent where applicable with the principles of reimbursement for provider costs in effect from time to time under Titles XVIII and XIX of the federal Social Security Act governing reimbursements or grants available to the commonwealth, its departments, agencies, boards, divisions or political subdivisions for general health supplies, care and rehabilitative services and accommodations.

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

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

Section 13E. Except for rates established under section 13F, any person, corporation or other party aggrieved by an interim rate or a final rate established by the executive office or a governmental unit designated to perform ratemaking functions by the executive office, or by failure of the executive office to set a rate or to take other action required by law and desiring a review thereof shall, within 30 days after said rate is filed with the state secretary or may, at any time, if there is a failure to determine a rate or take any action required by law, file an appeal with the division of administrative law appeals established by section 4H of chapter 7. Any

appeal filed under this section shall be accompanied by a certified statement that said appeal is not interposed for delay. On appeal, the rate determined for any provider of services shall be adequate, fair and reasonable for such provider, based upon, the costs of such provider, but not limited thereto.

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

Said decision shall contain a statement of the reasons for such decision, including a determination of each issue of fact or law upon which such decision was based. If such decision results in a recommendation for a rate different from that certified, the executive office shall establish a new rate based upon such statement of reasons. If the secretary of the executive office determines that the statement of reasons is inadequate to determine a fair, reasonable and adequate rate, it may remand the appeal to the hearing officer for further investigation. Any party aggrieved by a decision of the division may, within 30 days of the receipt of such decision, file a petition for review in superior court for the county of Suffolk, which shall have exclusive jurisdiction of such review.

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

The petition shall set forth the grounds upon which the decision of the division should be set aside. The aggrieved party shall, within 7 days after the petition for review is filed, notify the

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

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

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

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

Section 13F. All rates of payment to acute hospitals and non-acute hospitals under Title XIX shall be established by contract between the provider of such hospital services and the office of Medicaid, except as provided in subsections (a) and (b), or otherwise permitted by law. All rates shall be subject to all applicable Title XIX statutory and regulatory requirements and shall include reimbursement for the reasonable cost of providing competent interpreter services under section 25J of chapter 111 or section 23A of chapter 123.

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

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

(b) The executive office, or governmental unit designated by the executive office, shall establish rates of payment which shall apply to emergency services and continuing emergency care provided in acute hospitals to medical assistance program recipients, including examination or treatment for an emergency medical condition or active labor in women or any other care

rendered to the extent required by 42 USC 1395(dd), unless such services are provided under an agreement between the office of Medicaid and the acute hospital. Such rates of payment shall reflect the reasonable costs of providing such care, including the costs of providing competent interpreter services under section 25J of chapter 111 or section 23A of chapter 123 and shall take into account the characteristics of the hospital in which such care is provided, including, but not limited to, its status as a teaching hospital, specialty hospital, disproportionate share hospital, pediatric hospital, pediatric specialty unit or sole community provider. An acute hospital shall, when a medical assistance program recipient requires post emergency room care and, after screening and stabilizing the patient's condition, notify the office of Medicaid or its designated representative and assist said office, to the extent possible, in transferring the recipient to an appropriate medical setting under said office's direction. Nothing in this section shall be construed to require the hospital to breach its obligation under said 42 USC 1395(dd) or require the recipient to forego any right to refuse transfer under said 42 USC 1395(dd). If an acute hospital is unable or prohibited by law or regulation from transferring the patient under said office's direction, said executive office shall pay for any and all care associated with such patient's treatment including, but not limited to, care or services provided in the emergency room or in an inpatient or outpatient setting. Whenever said office is required to pay for such care rendered in a non-emergency room setting, said office shall pay all reasonable costs for such services in such hospital, as determined by the executive office under this chapter and consistent with Title XIX laws.

No acute hospital may charge to a governmental unit for services provided to publicly aided patients at a rate higher than the rate payable by the office of Medicaid under Title XIX for

the same service, unless such service is provided by said office under a unique arrangement such as a selective contract or a managed care contract.

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

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

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

Section 13G. The executive office, or a governmental unit designated to perform ratemaking functions by the executive office, shall not consider the following as resources of such hospitals in the establishment, review or approval of acute and non-acute hospital rates and

charges: restricted and unrestricted grants; gifts; contributions; bequests; fund principle; term endowments and endowment balances; restricted gifts; unrestricted gifts; and all income from any of the foregoing, including unrestricted income from endowment funds and income and gains from investment of unrestricted funds. The following words shall have the following meanings as used in this paragraph:

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

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

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

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

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

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

Section 13I. Notwithstanding any provisions of this chapter to the contrary, all costs and charges for patients who are residents of other countries shall, as provided herein, be exempted from the limitations imposed by this chapter. Any hospital shall be allowed to impose a surcharge on the normal charges that would otherwise be allowed for such residents of other

countries. Such surcharges shall not be included in the calculation of gross patient service revenues. The normal charge and the patient discharge statistics shall otherwise be included under this chapter.

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

Section 13K. Upon petition of a receiver appointed under section 72 N of chapter 111, the executive office shall, under regulations to be promulgated hereunder, adjust the facility's rate, if necessary, to insure compensation of the receiver and payment for a bond. Such adjustment shall not be in effect if the licensee is under the jurisdiction of the United States Bankruptcy Court.

SECTION 124. Section 14 of said chapter 118E, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 4 and 5 and 66, the words "division of health care finance and policy" and inserting in place thereof, in each instance, the following words:- executive office of health and human services or a governmental unit designated by the executive office.

SECTION 125. Section 17A of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 60 and 62, the word "physician" and inserting in place thereof, in each instance, the following word:- provider.

SECTION 126. Subsection (e) of section 22 of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 46 and 47, the words “36 of chapter 118G” and inserting in place thereof the following figure:- 66.

SECTION 127. Subsection (k) of said section 22 of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 93 and 96, the word “118G” and inserting in place thereof, in each instance, the following word:- 118E.

SECTION 128. Said section 22 of said chapter 118E, as so appearing, is hereby further amended by striking out, in lines 44 and 45, 65, 71, 86 and 87 and 110, the words “division of health care finance and policy” and inserting in place thereof, in each instance, the following words:- executive office of health and human services.

SECTION 129. Subsection (m) of said section 22 of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 112 and 113, the words “39 of chapter 118G” and inserting in place thereof the following figure:- 69.

SECTION 130. Section 23 of said chapter 118E, as so appearing, is hereby amended by striking out, in line 74, the words “39 of chapter 118G” and inserting in place thereof the following figure:- 69.

SECTION 131. Said chapter 118E is hereby further amended by inserting after section 62 the following 15 sections:—

Section 63. (a) For the purposes of this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

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

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

"Patient day", a day of care provided to an individual patient by a nursing home.

(b) Each nursing home shall pay an assessment per non-Medicare reimbursed patient day. The assessment shall be sufficient in the aggregate to generate $145 million in each fiscal year. The assessment shall be implemented as a broad based health care-related fee as defined in 42 U.S.C. § 1396b(w)(3)(B). The assessment shall be paid to the executive office quarterly. The executive office may promulgate regulations that authorize the assessment of interest on any unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees at a rate not to exceed 5 per cent per month. The receipts from the assessment, any federal financial participation received by the commonwealth as a result of expenditures funded by these assessments and interest thereon shall be credited to the General Fund.

(c) The secretary of the executive office shall prepare a form on which each nursing home shall report quarterly its total patient days and shall calculate the assessment due. The secretary of the executive office shall distribute the forms to each nursing home at least annually. The failure to distribute the form or the failure to receive a copy of the form shall not stay the obligation to pay the assessment by the date specified in this section. The executive office may

require additional reports, including but not limited to, monthly census data, as it considers necessary to monitor collections and compliance.

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

(e) In the event that a nursing home is aggrieved by a decision of the executive office as to the amount due, the nursing home may file an appeal to the division of administrative law appeals within 60 days of the date of the notice of underpayment or the date the notice was received, whichever is later. The division of administrative law appeals shall conduct each appeal as an adjudicatory proceeding under chapter 30A and a nursing home aggrieved by a decision of the division of administrative law appeals shall be entitled to judicial review under section 14 of said chapter 30A.

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

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

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

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

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

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

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

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

"Community health center", a health center operating in conformance with the requirements of Section 330 of United States Public Law 95-626, including all community health centers which file cost reports as requested by the center for health information and analysis.

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

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

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

"Emergency medical condition", a medical condition, whether physical, behavioral, related to a substance use disorder or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman.

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

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

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

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

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

"Health services", medically necessary inpatient and outpatient services as mandated under Title XIX of the federal Social Security Act; provided, that “health services” shall not include: (i) nonmedical services, such as social, educational and vocational services; (ii) cosmetic surgery; (iii) canceled or missed appointments; (iv) telephone conversations and consultations; (v) court testimony; (vi) 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 (vii) the provision of whole blood, but the administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

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

"Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge payors to acute hospitals for health services and ambulatory surgical centers for ambulatory surgical center services; provided, however, that "payments subject to surcharge" shall not include: (i) payments, settlements and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies; and (ii) payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in policies issued under chapter 176K or similar policies issued on a group basis; provided further, that "payments subject to surcharge" shall include payments made by a managed care organization on behalf of: (1) Medicaid recipients under age 65; and (2) enrollees in the commonwealth care health insurance program; and provided further, that "payments subject to surcharge" may exclude amounts established under regulations promulgated by the division for which the costs and efficiency of billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost effective.

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

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

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

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

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

"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, as defined in this section; 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.

"Underinsured patient", a patient whose health insurance plan or self-insurance health plan does not pay, in whole or in part, for health services that are eligible for reimbursement

from the health safety net trust fund, provided that such patient meets income eligibility standards set by the office.

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

Section 65. (a) There shall be established within the office of Medicaid a health safety net office which shall be under the supervision and control of a director. The director shall be appointed by the secretary of the executive office and shall be a person of skill and experience in the field of health care finance and administration. The director shall be the executive and administrative head of the office and shall be responsible for administering and enforcing the law relative to the office and to each administrative unit of the office. The director shall receive such salary as may be determined by law, and shall devote full time to the duties of the office. In the case of an absence or vacancy in the office of the director, or in the case of disability as determined by the secretary of the executive office, the secretary of the executive office may designate an acting director to serve as director until the vacancy is filled or the absence or disability ceases. The acting director shall have all the powers and duties of the director and shall have similar qualifications as the director.

(b) The office shall have the following powers and duties: (i) to administer the Health Safety Net Trust Fund, established under section 66, and to require payments to the fund consistent with acute hospitals' and surcharge payors' liability to the fund, as determined under sections 67 and 68, and any further regulations promulgated by the office; (ii) to set in consultation with the office of Medicaid, reimbursement rates for payments from the fund to

acute hospitals and community health centers for reimbursable health services provided to uninsured and underinsured patients and to disburse monies from the fund consistent with such rates; provided that the office shall implement a fee-for-service reimbursement system for acute hospitals; (iii) to promulgate regulations further defining: (1) eligibility criteria for reimbursable health services; (2) the scope of health services that are eligible for reimbursement by the Health Safety Net Trust Fund; (3) standards for medical hardship; and (4) standards for reasonable efforts to collect payments for the costs of emergency care; provided that the office shall verify eligibility using the eligibility system of the office of Medicaid and other appropriate sources to determine the eligibility of uninsured and underinsured patients for reimbursable health services and shall establish other procedures to ensure that payments from the fund are made for health services for which there is no other public or private third party payer, including disallowance of payments to acute hospitals and community health centers for health services provided to individuals if reimbursement is available from other public or private sources; (iv) to develop programs and guidelines to encourage maximum enrollment of uninsured individuals who receive health services reimbursed by the fund into health care plans and programs of health insurance offered by public and private sources and to promote the delivery of care in the most appropriate setting, provided that the programs and guidelines are developed in consultation with the commonwealth health insurance connector, established under chapter 176Q; and provided further that these programs shall not deny payments from the fund because services should have been provided in a more appropriate setting if the hospital was required to provide the services under 42 U.S.C. 1395 dd; (v) to conduct a utilization review program designed to monitor the appropriateness of services for which payments were made by the fund and to promote the delivery of care in the most appropriate setting; and to administer demonstration programs that

reduce health safety net trust fund liability to acute hospitals, including a demonstration program to enable disease management for patients with chronic diseases, substance abuse and psychiatric disorders through enrollment of patients in community health centers and community mental health centers and through coordination between these centers and acute hospitals, provided, that the office shall report the results of these reviews annually to the joint committee on health care financing and the house and senate committees on ways and means; (vi) to enter into agreements or transactions with any federal, state or municipal agency or other public institution or with a private individual, partnership, firm, corporation, association or other entity and to make contracts and execute all instruments necessary or convenient for the carrying on of its business; (vii) to secure payment, without imposing undue hardship upon any individual, for unpaid bills owed to acute hospitals by individuals for health services that are ineligible for reimbursement from the Health Safety Net Trust Fund which have been accounted for as bad debt by the hospital and which are voluntarily referred by a hospital to the department for collection; provided, however that such unpaid charges shall be considered debts owed to the commonwealth and all payments received shall be credited to the fund; and provided, further, that all actions to secure such payments shall be conducted in compliance with a protocol previously submitted by the office to the joint committee on health care financing; (viii) to require hospitals and community health centers to submit to the office data that it reasonably considers necessary; (ix) to make, amend and repeal rules and regulations to effectuate the efficient use of monies from the Health Safety Net Trust Fund; provided, however, that the regulations shall be promulgated only after notice and hearing and only upon consultation with the board of the commonwealth health insurance connector, representatives of the Massachusetts Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of

Massachusetts Safety Net Hospitals, the Conference of Boston Teaching Hospitals and the Massachusetts League of Community Health Centers; and (x) to provide an annual report at the close of each fund fiscal year to the joint committee on health care financing and the house and senate committees on ways and means, evaluating the processes used to determine eligibility for reimbursable health services, including the Virtual Gateway. The report shall include, but not be limited to, the following: (1) an analysis of the effectiveness of these processes in enforcing eligibility requirements for publicly-funded health programs and in enrolling uninsured residents into programs of health insurance offered by public and private sources; (2) an assessment of the impact of these processes on the level of reimbursable health services by providers; and (3) recommendations for ongoing improvements that will enhance the performance of eligibility determination systems and reduce hospital administrative costs.

Section 66. (a) There shall be established and set up on the books of the commonwealth a fund to be known as the Health Safety Net Trust Fund, in this section and in sections 67 to 69, inclusive, called the fund, which shall be administered by the office. Expenditures from the fund shall not be subject to appropriation unless otherwise required by law. The purposes of the fund shall be: (i) to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of reimbursable health services provided to low-income, uninsured or underinsured residents; and (ii) to support a portion of the costs of the Medicaid program this chapter and the commonwealth care health insurance program under chapter 118H. The office shall administer the fund using such methods, policies, procedures, standards and criteria that it deems necessary for the proper and efficient operation of the fund and programs funded by it in a manner designed to distribute the fund resources as equitably as possible. The

director of the health safety net office shall determine annually the estimated expenses of the office to administer the fund.

(b) The fund shall consist of all amounts paid by acute hospitals and surcharge payors under sections 67 and 68; all appropriations for the purpose of payments to acute hospitals or community health centers for health services provided to uninsured and underinsured residents; any transfers from the Commonwealth Care Trust Fund, established under section 2OOO of chapter 29; and all property and securities acquired by and through the use of monies belonging to the fund and all interest thereon. Amounts placed in the fund shall, except for amounts transferred to the Commonwealth Care Trust Fund, be expended by the office for payments to hospitals and community health centers for reimbursable health services provided to uninsured and underinsured residents of the commonwealth, consistent with the requirements of this section and section 69 and the regulations promulgated by the office; provided, however, that expenses of the health safety net office under subsection (a) shall be expended annually from the fund; and provided further, that not more than $6,000,000 shall be expended annually from the fund for demonstration projects that use case management and other methods to reduce the liability of the fund to acute hospitals; and provided further, that any amounts collected from surcharge payors in any year in excess of $160,000,000, adjusted to reflect applicable surcharge credits, shall be transferred to the General Fund to support a portion of the costs of the Medicaid and commonwealth care health insurance programs. Any annual balance remaining in the fund after these payments have been made shall be transferred to the Commonwealth Care Trust Fund. All interest earned on the amounts in the fund shall be deposited or retained in the fund. The director shall from time to time requisition from the fund amounts that the director considers

necessary to meet the current obligations of the office for the purposes of the fund and estimated obligations for a reasonable future period.

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

(b) The office shall establish by regulation an appropriate mechanism for enforcing an acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled payment to the fund. These enforcement mechanisms may include: (i) an offset by the office of Medicaid of payments on the Title XIX claims of any such acute hospital or any health care provider under common ownership with the acute care hospital or any successor in interest to the acute hospital; and (ii) the withholding by the office of Medicaid of the amount of payment owed to the fund, including any interest and late fees and the transfer of the withheld funds into the fund. If the office of Medicaid offsets claims payments as ordered by the office, it shall not be considered to be in breach of contract or any other obligation for the payment of non-contracted services and providers whose payment is offset under an order of the division shall serve all Title XIX recipients under the contract then in effect with the office of Medicaid, or, in the case of a non-contracting or disproportionate share hospital, under its obligation for providing services to

Title XIX recipients under this chapter. In no event shall the office direct the office of Medicaid to offset claims unless an acute hospital has maintained an outstanding obligation to the fund for a period longer than 45 days and has received proper notice that the office of Medicaid intends to initiate enforcement actions under regulations promulgated by the office.

Section 68. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge on all payments subject to surcharge as defined in section 64. The surcharge shall be distinct from any other amount paid by a surcharge payor for the services of an acute hospital or ambulatory surgical center. The surcharge amount shall equal the product of: (i) the surcharge percentage; and (ii) amounts paid for these services by a surcharge payor. The office shall calculate the surcharge percentage by dividing $160,000,000 by the projected annual aggregate payments subject to the surcharge, excluding projected annual aggregate payments based on payments made by managed care organizations. The office shall determine the surcharge percentage before the start of each fund fiscal year and may re-determine the surcharge percentage before April 1 of each fund fiscal year if the office projects that the initial surcharge percentage established the previous October will produce less than $150,000,000 or more than $170,000,000 in surcharge payments, excluding payments made by managed care organizations. Before each succeeding October 1, the office shall re-determine the surcharge percentage incorporating any adjustments from earlier years. In each determination or redetermination of the surcharge percentage, the office shall use the best data available as determined by the office of Medicaid and may consider the effect on projected surcharge payments of any modified or waived enforcement under subsection (e). The office shall incorporate all adjustments, including, but not limited to, updates or corrections or final settlement amounts, by prospective adjustment rather than by retrospective payments or assessments.

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

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

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

(e) The office shall establish by regulation an appropriate mechanism for enforcing a surcharge payor's liability to the fund if a surcharge payor does not make a scheduled payment to the fund; provided, however, that the office 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 surcharge payor, any entity under common ownership or any successor in interest to the 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 office, 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 a surcharge payor whose payment is offset under an order of the office 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 office direct the office of Medicaid to offset claims unless the surcharge payor has maintained an outstanding liability to the fund for a period longer than 45 days and has received proper notice that the office intends to initiate enforcement actions under regulations promulgated by the office.

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

Section 69. (a) Reimbursements from the fund to hospitals and community health centers for health services provided to uninsured and underinsured individuals shall be subject to further 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.

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

(7) The office shall reimburse acute hospitals for health services provided to individuals based on the payment systems in effect for acute hospitals used by the United States Department of Health and Human Services Centers for Medicare & Medicaid Services to administer the Medicare Program under Title XVIII of the Social Security Act, including all of Medicare's adjustments for direct and indirect graduate medical education, disproportionate share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of the annual increase in the Medicare hospital market basket index. The office shall, in consultation with the office of Medicaid and the Massachusetts Hospital Association, promulgate regulations necessary to modify these payment systems to account for: (i) the differences between the program administered by the office and the Title XVIII Medicare program, including the services and benefits covered; (ii) grouper and DRG relative weights for purposes of calculating the payment rates to reimburse acute hospitals at rates not less than the rates they are reimbursed by Medicare; (iii) the extent and duration of covered services; (iv) the populations served; and (v) any other adjustments to the payment methodology under this section as considered necessary by the office, based upon circumstances of individual hospitals.

Following implementation of this section, the office shall ensure that the allowable reimbursement rates under this section for health services provided to uninsured individuals shall not thereafter be less than rates of payment for comparable services under the Medicare program, 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.

Section 70. As used in sections 70 to 75 inclusive, the following words shall, unless the context requires otherwise, have the following meanings:—

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

“PCA quality home care workforce council”, “workforce council” or “the council”, the Personal Care Attendant quality home care workforce council established in section 71.

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

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

Section 71. (a) There shall be a PCA quality home care workforce council which shall be within the executive office of health and human services but shall not be subject to the control of the executive office, to ensure the quality of long-term, in-home, personal care by recruiting, training and stabilizing the work force of personal care attendants.

(b) The PCA quality home care workforce council shall consist of 9 members appointed under this section. A majority of the members of the council shall be consumers as defined in this chapter. In making appointments to the council, the governor shall appoint the secretary of the executive office of health and human services or a designee, who shall serve as chair, the secretary of labor and workforce development or a designee and 1 member from a slate of 3 consumers recommended by the governor's special advisory commission on disability policy.

The auditor shall appoint 1 member from a slate of 3 consumers recommended by the developmental disabilities council, 1 member from a slate of 3 consumers recommended by the Massachusetts office on disability, and 1 member from a slate of 3 consumers recommended by the statewide independent living council. The attorney general shall appoint 1 member from a slate of 3 consumers or consumer surrogates recommended by the Massachusetts home care association, 1 member from a slate of 3 consumers or consumer surrogates recommended by the Massachusetts council on aging and 1 member chosen by the attorney general. The secretary of health and human services or a designee and the secretary of labor and workforce development or a designee shall be permanent members during their term in office. Appointees to the council shall serve 3-year terms. If a vacancy occurs, the executive officer who made the original appointment shall appoint a new council member to serve the remainder of the unexpired term or, in the event that the vacancy occurs as the result of the completion of a term, to serve a full term, and such appointment shall become immediately effective upon the member taking the appropriate oath. If the departing council member was appointed under a recommendation made under this paragraph, the executive officer shall make the new appointment from a slate of 3 recommendations put forth by the entity that originally recommended the departing council member. Members of the council may serve for successive terms of office. A majority of the council shall constitute a quorum for the transaction of any business. Members of the council shall not receive compensation for their council service but members shall be reimbursed for their actual expenses necessarily incurred in the performance of their duties.

Section 72. (a) The workforce council shall carry out the following duties:

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

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

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

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

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

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

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

for the council and to provide consumers or the consumer's surrogate greater access to personal care attendant recruitment, training and referral resources in a cost-effective manner. Using requests for proposals or similar processes, the council may contract with the agencies to provide recruitment, training and referral. The council shall provide an opportunity for consumer participation in coordination efforts.

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

Section 73. (a) Consumers or the consumer's surrogate shall retain the right to select, hire, schedule, train, direct, supervise and terminate any personal care attendant providing services to the consumer or consumer's surrogate. Consumers or the consumer's surrogate may elect to receive long-term, in-home personal care services from personal care attendants who are not referred to the consumer or consumer's surrogate by the council.

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

said sections 17A, 17G and 17J of said chapter 180 and deductions under said sections 17A, 17G and 17J may be made by any entity authorized by the commonwealth to compensate personal care attendants through the MassHealth personal care attendant program. Personal care attendants shall not be eligible for benefits through the group insurance commission, the state board of retirement or the state employee workers' compensation program.

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

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

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

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

(g) The members of the council shall be immune from any liability resulting from implementation of sections 70 to 75, inclusive.

Section 74. (a) The PCA quality home care workforce council may make and execute contracts and all other instruments necessary or convenient for the performance of its duties or exercise of its powers, including contracts with public and private agencies, organizations, corporations and individuals to pay them for services rendered or furnished.

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

(c) The council may issue rules or regulations, as necessary, for the purpose and policies of sections 70 to 75, inclusive.

(d) Subject to appropriation, the chairperson of the council with the council's approval may establish offices, employ and discharge employees, agents and contractors as necessary and prescribe employees' duties and powers and fix the employees' compensation, incur expenses, and create such liabilities as are reasonable and proper for the administration of sections 70 to 75, inclusive.

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

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

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

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

(i) The council may acquire, hold or dispose of real or personal property, or any interest therein, and construct, lease or otherwise provide facilities for the activities conducted under sections 70 to 75, inclusive, but the workforce council may not exercise any power of eminent domain.

(j) The council may delegate to the appropriate persons the power to execute contracts and other instruments on its behalf and delegate any of its powers and duties, if consistent with sections 70 to 75, inclusive.

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

Section 75. (a) The council shall conduct a performance review every 2 years, submit a report of the review to the legislature and the governor and make the report available to the public upon submission to the governor and the legislature.

(b) The performance review and report shall include an evaluation of the health, welfare and satisfaction with services provided of the consumers receiving long-term in-home personal care services from personal care attendants under sections 70 to 75, inclusive, including the degree to which all required services have been delivered, the degree to which consumers

receiving services from personal care attendants have ultimately required additional or more intensive services, such as home health care, or have been placed in other residential settings or nursing homes, the promptness of response to consumer complaints and any other issue considered to be relevant.

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

(d) The performance review report shall make recommendations to the legislature and the governor for any amendments to sections 70 to 75, inclusive to further ensure the well-being of consumers, and the most efficient means of delivering required services.

Section 76. The secretary of the executive office may designate another governmental unit or units to perform any or all functions set forth in sections 13C to 13K, inclusive, and sections 64 to 75, inclusive. Such designee specifically may include the center for health information and analysis established under chapter 12C of the General Laws. The secretary may effectuate such designation through a memorandum of understanding, nonfinancial interdepartmental service agreement or similar instrument, and such designee shall be a party to any such instrument and perform the activities described therein.

Section 77. To the maximum extent possible, the office of Medicaid shall attribute every member to a primary care provider. Members may change their primary care provider, provided that the member gives notice to the office of Medicaid.

SECTION 132. Chapter 118G of the General Laws is hereby repealed.

SECTION 133. Chapter 118H of the General Laws is hereby amended by adding the following section:-

Section 7. To the maximum extent possible, the commonwealth care health insurance program shall attribute every member to a primary care provider. Members may change primary care providers, provided that the member gives notice to the commonwealth care health insurance program.

SECTION 134. The General Laws are hereby amended by inserting after chapter 118H the following chapter:—

CHAPTER 118I.

HEALTH INFORMATION TECHNOLOGY

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

"Commission", the health policy commission established in section 2 of chapter 6D.

"Council", the health information technology council established under section 2.

"Electronic health record," an electronic record of patient health information generated by 11or more encounters in any care delivery setting.

"Executive office", the executive office of health and human services.

"Health information exchange," an electronic platform enabling the transmission of healthcare-related data among providers, payers, personal health records controlled by a patient

and government agencies according to national standards, the reliable and secure transfer of data among diverse systems and access to and retrieval of data.

"Longitudinal medical record", a patient's lifetime electronic health record whether located, maintained or stored on a provider server, at a central storage repository, or distributed in multiple locations but accessible with patient consent.

"Massachusetts eHealth institute" or "institute", the Massachusetts e-Health institute established under section 6D of chapter 40J.

"Office of the National Coordinator" or "ONC", the Office of the National Coordinator for Health Information Technology within the United States Department of Health and Human Services.

"Statewide health information exchange", a health information exchange established, operated or funded by a governmental entity or entities in the commonwealth.

Section 2. (a) There shall be a health information technology council within the executive office of health and human services. The council shall coordinate with state agencies, including the commission, other governmental entities and private stakeholders to develop a statewide health information exchange. The council shall advise the executive office on design, implementation, operation and use of the statewide health information exchange and related infrastructure.

(b) The council shall consist of the following 21 members: the secretary of health and human services or a designee, who shall serve as the chair; the secretary of administration and finance or a designee; the executive director of the health policy commission or a designee; the

executive director of the center for health information analysis; the director of the Massachusetts e-Health Institute; the secretary of housing and economic development or a designee; the director of the office of Medicaid or a designee; and 14 members who shall be appointed by the governor, of whom at least 1 shall be an expert in health information technology; 1 shall be an expert in law and health policy; 1 shall be an expert in health information privacy and security; 1 shall be from an academic medical center; 1 shall be from a community hospital; 1 shall be from a community health center; 1 shall be from a long term care facility; 1 shall be a from large physician group practice; 1 shall be from a small physician group practice; 1 shall be a registered nurse; 1 shall be from a behavioral health, substance abuse disorder or mental health services organization; 1 shall represent health insurance carriers; and 2 additional members shall have experience or expertise in health information technology. The council may consult with all relevant parties, public or private, in exercising its duties under this section, including persons with expertise and experience in the development and dissemination of electronic health records systems, and the implementation of electronic health record systems by small physician groups or ambulatory care providers, as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, physicians and health insurers, the state quality improvement organization, academic and research institutions, consumer advisory organizations with expertise in health information technology and other stakeholders as identified by the secretary of health and human services. Appointed members of the council shall serve for terms of 2 years or until a successor 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,

auditing systems and any components necessary to connect the statewide health information exchange to provider electronic health records systems; and

(iv) take all actions necessary to directly manage the Office of the National Coordinator-HIE Cooperative Agreement and ONC Challenge Grant programs, including the termination of the current State Designated Entity delegation and the transfer of management responsibility of said ONC-HIE Cooperative Agreement from the Massachusetts e-Health Institute to the executive office.

Section 4. In carrying out of this chapter, the council shall consult with various organizations of regional payers and providers in developing the health information exchange plan and annual updates and in designing, developing, disseminating and implementing the health information exchange.

In carrying out this chapter, the executive office shall, to the maximum extent practicable, adopt policies that are consistent with those relating to similar subject matters adopted by the Office of the National Coordinator for Health Information Technology of the United States Department of Health and Human Services; provided, however, that nothing herein shall be construed to limit the executive office's ability to advance interoperability and other health information technology beyond the standards adopted by the ONC, including without limitation any applicable meaningful use standards.

Section 5. (a) The council shall approve all expenditures from the Massachusetts Health Information Exchange Fund established under section 10. The council, in consultation with the 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

patient's electronic health records with each of such patient's providers. The executive office shall ensure that the design of the statewide health information exchange includes the ability to transmit copies of electronic health records to patients directly or allow facilities to provide mechanisms for such patient to access such patient's own electronic health record.

Section 7. All providers in the commonwealth shall implement fully interoperable electronic health records systems that connect to the statewide health information exchange. The executive office, in consultation with the institute, shall ensure that the statewide health information exchange and associated electronic health records systems comply with all state and federal privacy requirements, including those 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 and 164.

Section 8. The executive office shall prescribe by regulation penalties for non-compliance by healthcare providers with the requirements of section 7; provided, however, that the executive office may waive penalties for good cause, including, but not limited to lack of broadband internet access as provided in section 9. Penalties collected under this section shall be deposited into the Prevention and Wellness Trust Fund, established in section 2G of chapter 111.

Section 9. If a provider is located in a geographic area of the commonwealth that does not have broadband internet access and, due to lack of such broadband internet access, such provider is unable to fully comply with the requirements of the health information exchange and any other health information technology requirements implemented by the executive office under this chapter, such provider may apply to the executive office for a temporary waiver of any specific requirement with which it is unable to comply. If the executive office determines that

the provider is unable to comply with a requirement due to the lack of broadband internet access, the executive office may grant a waiver of such requirement; provided, however, that, upon a determination by the executive office that broadband internet access has become available to such provider since the date of the grant of the waiver, the executive office shall notify such provider of such availability. Within 180 days of such notice, such provider shall take such actions as are necessary to bring the provider into full compliance with the requirements of the health information exchange and any other health information technology requirements implemented by the executive office under this chapter.

Section 10. There shall be established and set up on the books of the executive office the Massachusetts Health Information Exchange Fund, referred to in this section as the fund, for the purpose of developing a statewide health information exchange. There shall be credited to the fund any appropriations, proceeds of any bonds or notes of the commonwealth issued for the purpose, or other monies authorized by the general court and designated thereto; 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 executive office shall seek, to the greatest extent possible, private gifts, grants and donations to the fund. The executive office shall hold the fund in an account or accounts separate from other funds. The fund shall be administered by the executive office without further appropriation. Amounts credited to the fund shall be available for reasonable expenditure by the executive office, subject to the approval of the council where such approval is required under this chapter, for such purposes as the executive office determines are necessary to support the dissemination and development of the statewide health information exchange. The secretary of administration and finance shall transfer a portion of (i) any money in the E-Health Institute Fund, (ii) any money from the ONC Health

Information Exchange Cooperative Agreement, or (iii) the ONC Health Information Exchange Challenge Grant programs that is related to the implementation of the statewide health information exchange.

Section 11. Any plan approved by the executive office and council or the e-Health institute, including every grantee and implementing organization that receives monies funded in whole or in part from the e-Health Institute Fund established in section 6E of chapter 40J or the Massachusetts Health Information Exchange Fund established under section 10, shall:

(1) establish a mechanism to allow patients to opt-in to the health information exchange and to opt-out at any time;

(2) maintain identifiable health information in physically and technologically secure environments by means including, but not limited to: prohibiting the storage or transfer of unencrypted and non-password protected identifiable health information on portable data storage devices; requiring data encryption, unique alpha-numerical identifiers and password protection; and other methods to prevent unauthorized access to identifiable health information;

(3) provide patients the option of, upon request to a provider, obtaining a list of individuals and entities that have accessed their identifiable health information from that provider;

(4) develop and distribute to authorized users of the health information exchange and to prospective exchange participants, written guidelines addressing privacy, confidentiality and security of health information and inform individuals: the information available through the exchange, who may access their information and the purposes for which their information may be accessed; and

(5) ensure compliance with all state and federal privacy requirements, including those 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 and 164.

Section 12. In the event of an unauthorized access to or disclosure of individually identifiable patient health information by or through the statewide health information exchange or by or through any technology grantees or implementing organizations funded in whole or in part from the e-Health Institute Fund established in section 6E of chapter 40J or the Massachusetts Health Information Exchange Fund established in section 10, the operator of such exchange or grantee or contractor shall: (i) report the conditions of such unauthorized access or disclosure as required by the executive office; and (ii) provide notice, as defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days after such unauthorized access or disclosure, to any person whose patient health information may have been compromised as a result of such unauthorized access or disclosure, and shall report the conditions of such unauthorized access or disclosure. Any unauthorized access or disclosures shall be punishable by the civil penalties under section 16.

Section 13. The ability of any provider to transfer or access all or any part of a patient's electronic health record under this chapter shall be subject to the patient's election to participate in the electronic health information exchange as provided in section 11

Section 14. The executive office, the council and the institute shall pursue and maximize all opportunities to qualify for federal financial participation under the matching grant program established under the Health Information Technology for Economic and Clinical Health Act of

the American Recovery and Reinvestment Act of 2009, P.L. 111-5. The council shall consult with the office of Medicaid to maximize all opportunities to qualify any expenditure for any other federal financial participation.

Section 15. The council shall file an annual report, not later than January 30, with the joint committee on health care financing, the joint committee on economic development and emerging technologies, the house and senate committees on ways and means and the clerks of the house and senate concerning the activities of the council in general and, in particular, describing the progress to date in developing a statewide health information exchange and recommending such further legislative action as it deems appropriate.

Section 16. Unauthorized access to or disclosure of individually identifiable patient health information by or through the statewide health information exchange or by or through any technology grantees or implementing organizations funded in whole or in part from the from the e-Health Institute Fund established in section 6E of chapter 40J or the Massachusetts Health Information Exchange Fund established in section 10, or any associated businesses managing or in possession of such information, the operator of such exchange or grantee or contractor shall be subject to fines or penalties as determined by the executive office. The executive office shall promulgate regulations to assess fair and reasonable fines or penalties.

SECTION 135. Section 14 of chapter 122 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 17 and 18, the words “division of health care finance and policy” and inserting in place thereof the following words:- executive office of health and human services or a governmental unit designated by the executive office.

SECTION 136. Section 32 of chapter 123 of the General Laws, as so appearing, is hereby amended by striking out, in lines 4 and 5, the words “division of health care finance and policy” and inserting in place thereof the following words:- executive office of health and human services or a governmental unit designated by the executive office.

SECTION 137. Section 33 of said chapter 123, as so appearing, is hereby amended by striking out, in lines 20 and 25, the words “division of health care finance and policy” and inserting in place thereof, in each instance, the following words:- executive office of health and human services or a governmental unit designated by the executive office.

SECTION 138. Section 16 of chapter 123B of the General Laws, as so appearing, is hereby amended by striking out, in lines 4 and 5, the words “division of health care finance and policy” and inserting in place thereof the following words:- executive office of health and human services or a governmental unit designated by the executive office.

SECTION 139. Chapter 149 of the General Laws is hereby amended by striking out section 6D ½, as so appearing, and inserting in place thereof the following section:-

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

SECTION 140. Said chapter 149 is hereby further amended by striking out section 188, as so appearing, and inserting in place thereof the following section:—

Section 188. (a) As used in this section, the following words, unless the context clearly requires otherwise, shall have the following meanings:--

“Authority”, the commonwealth health insurance connector authority.

"Contributing employer", an employer that offers a group health plan, as defined in 26 U.S.C. 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as defined in regulation by the authority.

"Department", the department of unemployment assistance.

"Employee", an individual employed by an employer subject to this chapter for at least 1 month, provided that for the purpose of this section self-employed individuals shall not be considered employees.

"Employer", an employing unit as defined in section 1 of chapter 151A or in section 1 of chapter 152.

(b) To more equitably distribute the costs of health care provided to uninsured residents of the commonwealth, each employer that: (1) employs 11 or more full-time equivalent employees in the commonwealth and (2) is not a contributing employer shall pay a per-employee contribution at a time and in a manner prescribed by the director of unemployment assistance, in this section called the fair share employer contribution. This contribution shall be pro-rated by a fraction which shall not exceed 1, the numerator of which is the number of hours worked in the quarter by all of the employer's employees and the denominator of which is the product of the number of employees employed by an employer during that quarter multiplied by 500 hours.

(c) The executive director of the authority shall, in consultation with the director of unemployment assistance, annually determine the fair share employer contribution rate based on the best available data and under the following provisions:-

(1) The per-user share of private sector liability shall be calculated annually by dividing the sum of hospital liability and third-party payor liability for uncompensated care, as defined by law, by the total number of individuals in the most recently completed fiscal year whose care was reimbursed in whole or in part by thehealth safety net.

(2) The total number of employees in the most recent fiscal year on whose behalf health care services were reimbursed in whole or in part by the health safety net, shall be calculated. In calculating this number, the authority shall use all resources available to enable it to determine the employment status of individuals for whom reimbursements were made, including quarterly wage reports maintained by the department of revenue.

(3) The total number of employees as calculated in paragraph (2) shall be adjusted by multiplying that number by the percentage of employers in the commonwealth that are not contributing employers, as determined by the authority.

(4) The total cost of liability associated with employees of non- contributing employers shall be determined by multiplying the number of employees, as calculated in paragraph (3) by the per-user share of private sector liability as calculated in paragraph (1).

(5) The fair share employer contribution shall be calculated by dividing the total cost of liability as calculated in paragraph (4) by the total number of employees of employers that are not contributing employers, as determined by the authority.

(6) The fair share employer contribution, as determined in paragraph (5) shall be adjusted annually to reflect medical inflation, using an appropriate index as determined by the authority.

(7) The total dollar amount of health care services provided by physicians to non-elderly, uninsured residents of the commonwealth for which no reimbursement is made from the Health Safety Net Trust Fund shall be calculated using a survey of physicians or other data source that the authority determines is most accurate.

(8) The per-employee cost of uncompensated physician care shall be calculated by dividing the dollar amount of such services, as calculated in paragraph (7) by the total number of employees of contributing employers in the commonwealth, as estimated by the authority using the most accurate data source available, as determined by the authority.

(9) The annual fair share employer contribution shall be calculated by adding the fair share employer contribution as calculated in paragraph (6) and the per-employee cost of unreimbursed physician care, as calculated in paragraph (8).

(10) Notwithstanding this section, the total annual fair share employer contribution shall not exceed $295 per employee which may be made in a single payment or in equal amounts semi-annually or quarterly, at the employer's discretion.

(d) The director of unemployment assistance shall determine quarterly each employer's liability for its fair share employer contribution. The director shall assess each employer liable for a fair share employer contribution in a quarter an amount based on 25 per cent of the annual fair share employer contribution rate applicable to that quarterly period and shall implement penalties for employers who fail to make contributions as required by this section. In order to

reduce the administrative costs of collection of contributions, the director shall, to the extent possible, use any existing procedures implemented by the department of unemployment assistance to make similar collections. Amounts collected pursuant to this section shall be deposited in the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29. Before depositing the amounts, the director may deduct all administrative costs incurred by the department of unemployment assistance as a result of this section, including an amount as determined by the United States Secretary of Labor in accordance with federal cost rules. Except where inconsistent with this section, the terms and conditions of chapter 151A which are applicable to the payment and collection of contributions shall apply to the same extent to the payment and collection of any obligation under this section. The department of unemployment assistance shall promulgate regulations necessary to implement this section.

(e) In promulgating regulations defining the term "contribution" under this section, no proposed regulation by the authority, except an emergency regulation, shall take effect until 60 days after the proposed regulations have been transmitted to the joint committee on health care financing and the joint committee on financial services.

SECTION 141. Subsection (b) of said section 188 of said chapter 149, as appearing in section 140, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:-

To more equitably distribute the costs of health care provided to uninsured residents of the commonwealth, each employer that: (1) employs 21 or more full-time equivalent employees in the commonwealth and (2) is not a contributing employer shall pay a per-employee

contribution at a time and in a manner prescribed by the director of unemployment assistance, in this section called the fair share employer contribution.

SECTION 142. Subsection (c) of said section 188 of said chapter 149, as so appearing, is hereby amended by adding the following clause:-

(11) In calculating the fair share assessment, employees who have qualifying health insurance coverage from a spouse, parent, veteran's plan, Medicare, or a plan or plans due to disability or retirement shall not be included in the numerator or denominator for purposes of determining whether an employer is a contributing employer, as defined by 114.5 CMR 16.02. The employer shall keep and maintain proof of their employee's insurance status, in a reasonable manner as defined by the authority.

SECTION 143. Section 1 of chapter 150E of the General Laws, as amended by section 23 of chapter 93 of the acts of 2011, is hereby amended by striking out the words "28 of chapter 118G" and inserting in place thereof the following words:- 70 of chapter 118E.

SECTION 144. Said section 1 of said chapter 150E of the General Laws, as so amended, is hereby further amended by striking out the words "29 of chapter 118G" and inserting in place thereof the following words:- 71 of chapter 118E.

SECTION 145. Subsection (c) of section 46 of chapter 151A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out clause (7) and inserting in place thereof the following 2 clauses:-

(7) to the commonwealth health insurance connector, information under an interagency agreement for the administration and enforcement of sections 17 and 18 of chapter 176Q and for

the administration of the fair share employer contribution requirement under section 188 of chapter 149.

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

SECTION 146. Section 13 of chapter 152 of the General Laws, as so appearing, is hereby amended by striking out, in lines 3 and 4, the words “division of health care finance and policy under the provisions of chapter one hundred and eighteen G” and inserting in place thereof the following words:- executive office of health and human services under chapter 118E or a governmental unit designated by the executive office.

SECTION 147. Said section 13 of said chapter 152, as so appearing, is hereby further amended by striking out, in lines 9, 10, 16 and 21, the word “division” and inserting in place thereof, in each instance, the following words:- executive office.

SECTION 148. Said section 13 of said chapter 152, as so appearing, is hereby further amended by striking out, in lines 22 and 23, the words “one hundred and eighteen G” and inserting in place thereof the following word:- 118E.

SECTION 149. Said section 13 of said chapter 152, as so appearing, is hereby further amended by striking out, in line 37 and 38, the words “one hundred and eighteen G” and inserting in place thereof, in each sentence, the following word:- 118E.

SECTION 150. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Net value of policies” the following definition:-

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

SECTION 152. Section 47B of said chapter 175, as so appearing, is hereby amended by striking out, in line 46, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 153. Section 47U of said chapter 175, as so appearing, is hereby amended by striking out, in lines 62 and 64, the word “physician” and inserting in place thereof, in each instance, the following word :- provider.

SECTION 154. Section 108 of said chapter 175, as so appearing, is hereby amended by adding the following clause:—

13. Any policy of accident and sickness shall include a premium rate adjustment based on employee participation in a qualified wellness program. The division shall determine by regulation the criteria for a qualified wellness program to determine eligibility 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 155. Said chapter 175 is hereby further amended by inserting after section 108J the following 2 sections:—

Section 108L. To the maximum extent possible, carriers that offer any policy of accident and sickness insurance or any general or blanket policy of insurance shall attribute every member to a primary care provider. Members may change their primary care provider, provided that the member gives notice to the carrier.

Section 108M. To the extent permissible under applicable state and federal privacy laws, carriers shall disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers and managing the care of their own patient panel; provided, that an individual provider shall only receive patient-level data related to patients treated by said provider. Patient-level data shall include, but not be limited to, health care service utilization, medical expenses, and demographics.

The division of insurance shall develop procedures and a standard format for disclosing such patient-level information. The division may require carriers to disclose such information through the all-payer claims database established under section 12 of chapter 12C if the division and the center for health information and analysis determine that the all-payer claims database is an efficient means to provide such information.

Carriers shall make available to any provider with whom they have entered into an alternative payment contract, the contracted prices of individual health care services within such payer's network for the purpose of referrals.

SECTION 158. Chapter 175 of the General Laws is hereby amended by inserting after section 47AA, the following section:—

Section 47BB. (a) For the purposes of this section, "telemedicine" as it pertains to the delivery of health care services, shall mean the use of interactive audio, video or other electronic

media for the purpose of diagnosis, consultation or treatment. “Telemedicine” shall not include the use of audio-only telephone, facsimile machine or e-mail.

(b) An insurer may limit coverage of telemedicine services to those health care providers in a telemedicine network approved by the insurer.

(c) A contract that provides coverage for services under this section may contain a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telemedicine as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

(d) Coverage for health care services under this section shall be consistent with coverage for health care services provided through in-person consultation.

SECTION 159. Section 5 of chapter 176A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 34 and 35, the words “division of health care finance and policy, in this section called the division” and inserting in place thereof the following words:- executive office of health and human services, in this section called the executive office, or a governmental unit designated by the executive office.

SECTION 160. Section 8A of chapter 176A of the General Laws, as so appearing, is hereby amended by striking out, in line 41, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 161. Subsection (c) of said section 8A of chapter 176A, as so appearing, is hereby amended by adding the following paragraph:-

For the purposes of this subsection, the term “primary care provider” shall mean a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.

SECTION 162. Paragraph (a) of section 8U of chapter 176A, as so appearing, is hereby amended by inserting after the definition of “Insured” the following definition:-

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

SECTION 163. Said section 8U of said chapter 176A, as so appearing, is hereby amended by striking out, in lines 64 and 66, the word “physician” and inserting in place thereof the following word in each instance:- provider.

SECTION 164. Section 17 of said chapter 176A, as so appearing, is hereby amended by striking out, in lines 4 and 10, the words “division of health care finance and policy” and inserting in place thereof, in each instance, the following words:- center for health information and analysis.

SECTION 165. Said chapter 176A is hereby further amended by adding the following 2 sections:—

Section 36. To the maximum extent possible, every non-profit hospital service corporation shall attribute every member to a primary care provider. Members may change their primary care provider, provided that the member gives notice to the carrier.

Section 37. To the extent permissible under applicable state and federal privacy laws, every non-profit hospital service corporation shall disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers and managing the care of their own patient panel; provided, that an individual provider shall only receive patient-level data related to patients treated by said provider. Patient-level data shall include, but not be limited to, health care service utilization, medical expenses, and demographics.

The division of insurance shall develop procedures and a standard format for disclosing such patient-level information. The division may require every non-profit hospital service corporation to disclose such information through the all-payer claims database established under section 12 of chapter 12C if the division and the center for health information and analysis determine that the all-payer claims database is an efficient means to provide such information.

Non-profit hospital service corporations shall make available to any provider with whom they have entered into an alternative payment contract, the contracted prices of individual health care services within such payer's network for the purpose of referrals.

SECTION 166. Section 1 of chapter 176B of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after the definition of "Participating optometrist" the following definition:-

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

SECTION 167. Section 4A of said chapter 176B, as so appearing, is hereby amended by striking out, in line 43, the word "physician" and inserting in place thereof the following word:- provider.

SECTION 168. Section 4U of said chapter 176B, as so appearing, is hereby amended by striking out, in lines 64 and 66, the word "physician" and inserting in place thereof the following word in each instance:- provider.

SECTION 169. Said chapter 176B is hereby further amended by adding the following 2 sections:-

Section 23. To the maximum extent possible, every medical service corporation shall attribute every member to a primary care provider. Members may change their primary care provider, provided that the member gives notice to the carrier.

Section 24. To the extent permissible under applicable state and federal privacy laws, every medical service corporation shall disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers and managing the care of their own patient panel; provided, that an individual provider shall only receive patient-level data related to patients treated by said provider. Patient-level data shall include, but not be limited to, health care service utilization, medical expenses, and demographics.

The division of insurance shall develop procedures and a standard format for disclosing such patient-level information. The division may require every medical service corporation to disclose such information through the all-payer claims database established under section 12 of chapter 12C if the division and the center for health information and analysis determine that the all-payer claims database is an efficient means to provide such information.

Medical service corporations shall make available to any provider with whom they have entered into an alternative payment contract, the contracted prices of individual health care services within such payer's network for the purpose of referrals.

SECTION 170. Section 1 of chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after the definition of "Person" the following definition:-

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

SECTION 171. Section 4M of said chapter 176G, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 40, the word "physician" and inserting in place thereof the following word:- provider.

SECTION 172. Section 5 of said chapter 176G, as so appearing, is hereby amended by striking out, in lines 59 and 61, the word "physician" and inserting in place thereof, in each instance, the following word:- provider.

SECTION 173. Chapter 176G of the General Laws is hereby amended by adding the following 2 sections:—

Section 31. To the maximum extent possible, every health maintenance organization shall attribute every member to a primary care provider. Members may change their primary care provider, provided that the member gives notice to the carrier.

Section 32. To the extent permissible under applicable state and federal privacy laws, every health maintenance organization shall disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers and managing the care of their own patient panel; provided, that an individual provider shall only receive patient-level data related to patients treated by said provider. Patient-level data shall include, but not be limited to, health care service utilization, medical expenses, and demographics.

The division of insurance shall develop procedures and a standard format for disclosing such patient-level information. The division may require every health maintenance organization to disclose such information through the all-payer claims database established under section 12 of chapter 12C if the division and the center for health information and analysis determine that the all-payer claims database is an efficient means to provide such information.

Health maintenance organizations shall make available to any provider with whom they have entered into an alternative payment contract, the contracted prices of individual health care 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

of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals, shall offer to all eligible individuals and small businesses in at least 1 geographic area at least 1 plan with either:

(1) a reduced or selective network of providers;

(2) a smart tiering plan in which health services are tiered and member cost sharing is based on the tier placement of the services; or,

(3) a plan in which providers are tiered and member cost sharing is based on the tier placement of the provider.

The commissioner of insurance shall annually determine a base premium rate discount of at least 14 per cent for the reduced or selective or tiered network plan compared to the base premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-tiered network of providers. The savings may be achieved by means including, but not limited to: (i) the exclusion of providers with similar or lower quality based on the standard quality measure set with higher health status adjusted total medical expenses or relative prices, as determined under section 10 of chapter 12C; or (ii) increased member cost-sharing for members who utilize providers for non-emergency services with similar or lower quality based on the standard quality measure set and with higher health status adjusted total medical expenses or relative prices, as determined under said section 10 of said chapter 12C.

The commissioner may apply waivers to the base premium rate discount determined by the commissioner under this section to carriers who receive 80 per cent or more of their incomes

from government programs or which have service areas which do not include either Suffolk or Middlesex counties and who were first admitted to do business by the division of insurance on January 1, 1988, as health maintenance organizations under chapter 176G.

(b) A tiered network plan shall only include variations in member cost-sharing between provider tiers which are reasonable in relation to the premium charged and ensure adequate access to covered services. Carriers shall tier providers based on quality performance as measured by the standard quality measure set and by cost performance as measured by health status adjusted total medical expenses and relative prices. Where applicable quality measures are not available, tiering may be based solely on health status adjusted total medical expenses or relative prices or both. Smart tiering plans may take into account the number of services performed each year by the provider. For smart tiering plans, if a medically necessary and covered service is available at not more than 5 facilities in the state, as determined by the health policy commission, that service shall not be placed into the most expensive cost-sharing tier.

The commissioner shall promulgate regulations requiring the uniform reporting of tiering information, including, but not limited to, requiring at least 90 days before the proposed effective date of any tiered network plan or any modification in the tiering methodology for any existing tiered network plan, the reporting of a detailed description of the methodology used for tiering providers, including: the statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a description of how the methodology and resulting tiers will be communicated to each network provider, eligible individuals and small groups; and a description of the appeals process a provider may pursue to challenge the assigned tier level.

(c) The commissioner shall determine network adequacy for a tiered network plan based on the availability of sufficient network providers in the carrier's overall network of providers.

(d) The commissioner shall determine network adequacy for a selective network plan based on the availability of sufficient network providers in the carrier's selective network.

(e) In determining network adequacy under this section the commissioner of insurance may take into consideration factors such as the location of providers participating in the plan and employers or members that enroll in the plan, the range of services provided by providers in the plan and plan benefits that recognize and provide for extraordinary medical needs of members that may not be adequately dealt with by the providers within the plan network.

(f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in selective and tiered plans not more than once per calendar year except that carriers may reclassify providers from a higher cost tier to a lower cost tier or add providers to a selective network at any time. If the carrier reclassifies provider tiers or providers participating in a selective plan during the course of an account year, the carrier shall provide affected members of the account with information regarding the plan changes at least 30 days before the changes take effect. Carriers shall provide information on their websites about any tiered or selective plan, including but not limited to, the providers participating in the plan, the selection criteria for those providers and where applicable, the tier in which each provider is classified.

(g) A smart tiering plan shall be a tiering product, which offers a cost-sharing differential based on services rather than facilities providing services. A service covered in a smart tiering 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 prodcut 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

products. The report shall be submitted to clerks of the house of representatives and the senate, the senate and house committees on ways and means and the joint committee on health care financing.

SECTION 178. Section 12 of said chapter 176J, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 59 and 60, the words “division of health care finance and policy” and inserting in place thereof the following words:- center for health information and analysis.

SECTION 179. Said section 12 of said chapter 176J, as so appearing, is hereby further amended by adding the following subsection:—

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

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

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

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

SECTION 180. Said chapter 176J is hereby further amended by adding the following 2 sections:-

Section 16. To the maximum extent possible, carriers shall attribute every member to a primary care provider. Members may change their primary care provider, provided that the member gives notice to the carrier.

Section 17. To the extent permissible under applicable state and federal privacy laws, every carrier shall disclose patient-level data to providers in their network solely for the purpose of carrying out treatment, coordinating care among providers and managing the care of their own patient panel; provided, that an individual provider shall only receive patient-level data related to patients treated by said provider. Patient-level data shall include, but not be limited to, health care service utilization, medical expenses, and demographics.

The division of insurance shall develop procedures and a standard format for disclosing such patient-level information. The division may require carriers to disclose such information through the all-payer claims database established under section 12 of chapter 12C if the division and the center for health information and analysis determine that the all-payer claims database is an efficient means to provide such information.

Carriers shall make available to any provider with whom they have entered into an alternative payment contract, the contracted prices of individual health care services within such payer’s network for the purpose of referrals.

SECTION 181. Section 5 of chapter 176M of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 94 to 96, inclusive, the words "division of health care finance and policy established under chapter one hundred and eighteen G" and inserting in place thereof the following words:- center for health information and analysis established under chapter 12C.

SECTION 182. Said section 5 of said chapter 176M, as so appearing, is hereby further amended by striking out, in line 99, the word "division" and inserting in place thereof the following word:- center.

SECTION 183. Section 1 of said chapter 176O of the General Laws, as so appearing, is hereby amended by striking out the definition of "Behavioral health manager" and inserting in place thereof the following definition:-

"Behavioral health manager", a company, organized under the law of the commonwealth or organized under the laws of another state and qualified to do business in the commonwealth, that has entered into a contractual arrangement with a carrier to provide or arrange for the provision of behavioral, substance use disorder and mental health services to voluntarily enrolled member of the carrier.

SECTION 184. Said section 1 of said chapter 176O , as so appearing, is hereby further amended by inserting after the definition of "Division" the following definition:

"Downside risk", the risk taken on by a provider organization as part of an alternate payment contract with a carrier or other payer where the provider organization is responsible for either the full or partial costs of treating a group of patients that exceeds a contract's budgeted payment arrangements.

SECTION 185. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by striking out the definition of "Emergency medical condition" and inserting in place thereof the following definition:-

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

SECTION 186. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by striking out the definition of "Health care services" and inserting in place thereof the following definition:-

"Health care services", services for the diagnosis, prevention, treatment, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

SECTION 187. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by inserting after the definition of "Person" the following definition:-

"Primary care provider", a health care professional qualified to provide general medical 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.

SECTION 193. Clause (1) of subsection (a) of section 7 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 18 and 19, the words “6 of chapter 118G” and inserting in place thereof the following words:- 10 of chapter 12C.

SECTION 194. Said section 7 of said chapter 176O, as so appearing, is hereby further amended by striking out, in lines 20 and 21, the words “6 of said chapter 118G” and inserting in place thereof the following words:- 10 of said chapter 12C.

SECTION 195. Said section 7 of said chapter 176O, as so appearing in the 2010 Official Edition, is hereby further amended by striking out, in line 48, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 196. Section 9A of said chapter 176O, as so appearing, is hereby amended by striking out, in line 25, the words “6 of chapter 118G” and inserting in place thereof the following words:- 10 of chapter 12C; and.

SECTION 197. Said section 9A of said chapter 176O, as so appearing, is hereby amended by adding the following 2 subsections:—

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

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

SECTION 198. Said chapter 176O is hereby further amended by inserting after section 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

or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

Adverse determinations rendered by a program of utilization review or other denials of requests for health services, shall be made by a person licensed in the appropriate specialty related to such health service and, if applicable, by a provider in the same licensure category as the ordering provider.

SECTION 200. Said section 12 of said chapter 176O, as so appearing, is hereby further amended by adding the following subsection:-

(f) Upon request by an insured or insured's treating health care provider, a carrier or utilization review organization shall make a determination regarding whether a proposed admission, procedure or service is medically necessary within 7 working days of obtaining all necessary information, except that a carrier or utilization review organization may choose not to perform such a review if the carrier or utilization review organization determines that the admission, procedure or service will be covered. Nothing in this subsection shall:- (i) require a treating health care provider to obtain information regarding whether a proposed admission, procedure or service is medically necessary on behalf of an insured; (ii) restrict the ability of a carrier or utilization review organization to deny a claim for an admission, procedure or service if the admission, procedure or service was not medically necessary, based on information 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

the carrier's network if: (1) the insured's employer only offers the insured a choice of carriers in which said provider is not a participating provider, and (2) said provider is providing the insured with an ongoing course of treatment or is the insured's primary care provider. With respect to an insured in her second or third trimester of pregnancy, this subsection shall apply to services rendered through the first postpartum visit. With respect to an insured with a terminal illness, this subsection shall apply to services rendered until death.

(e) A carrier may condition coverage of continued treatment by a provider under subsections (a) to (d), inclusive, upon the provider's agreeing: (1) to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and (3) to adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services under a treatment plan, if any, approved by the carrier. Nothing in this subsection shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(f) A carrier that requires an insured to designate a primary care provider shall allow such a primary care provider to authorize a standing referral for specialty health care provided by a health care provider participating in such carrier's network when (1) the primary care provider determines that such referrals are appropriate, (2) the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care provider with all necessary clinical and administrative information on a regular basis, and (3) the health care services to be provided

are consistent with the terms of the evidence of coverage. Nothing in this section shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(g) No carrier shall require an insured to obtain a referral or prior authorization from a primary care provider for specialty care provided by an obstetrician, gynecologist, certified nurse-midwife or family practitioner participating in such carrier's health care provider network for the following: (1) annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse-midwife or family practitioner to be medically necessary as a result of such examination; (2) maternity care; and (3) medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions. No carrier shall require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care provider. Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse-midwives or family practitioners to communicate with an insured's primary care provider regarding the insured's condition, treatment and need for follow-up care. Nothing in this section shall be construed to permit an obstetrician, gynecologist, certified nurse-midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(h) A carrier shall provide coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such 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

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. If a carrier or utilization review organization intends either to implement a new medical necessity guideline or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction.

SECTION 203. Section 20 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 19 and 22, the words "care physician" and inserting in place thereof, in each instance, the following words:- "care provider".

SECTION 204. Section 21 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 109 and 110, the words "division of health care finance and policy for use under section 6 of chapter 118G" and inserting in place thereof the following words:- center for health information and analysis for use under section 10 of chapter 12C.

SECTION 205. Said section 21 of said chapter 176O, as so appearing, is hereby further amended by adding the following section:

(e) The commissioner may waive specific reporting requirements in this section for classes of carriers for which the commissioner deems such reporting requirements to be inapplicable; provided, however, that the commissioner shall provide written notice of any such waiver to the joint committee of health care financing and the house and senate committees on 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 that 3 days for a patient with an urgent medical need including, but not limited

to, terminal illness or emergency situations, as defined through regulations by the office of patient protection. During the appeals process, the risk-bearing provider organization shall not: (i) prevent a patient from seeking medical opinions outside of that organization; or (ii) terminate any medical services being provided to the patient, including medical services which began prior to the appeal and are the subject of such appeal. The decision on the appeal shall be in writing and shall notify the patient of the right to file a further external appeal.

(c) Risk-bearing provider organizations shall inform any patient of the right to designate a third party to advocate on the patient's behalf during the appeals process including, but not limited to, a spouse or other family member, an attorney of record or a legal guardian. If the patient does not elect a person to serve as his or her advocate such provider organization shall offer to contact the office of patient protection and the office of patient protection may designate an ombudsman to advocate on the patient's behalf.

(d) The office of patient protection shall establish by regulation an external review process for the review of grievances submitted by or on behalf of patients of risk-bearing provider organizations. The process shall specify the maximum amount of time for the completion of a determination and review after a grievance is submitted and shall include the right to have benefits continued pending appeal. The office of patient protection shall establish expedited review procedures applicable to emergency and urgent care situations

(e) The office of patient protection shall promulgate regulations necessary to implement 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

any entity acting for a payer under contract shall accept the form as sufficient to request prior authorization for the health care service or benefit.

Nothing in this section shall prohibit a payer or any entity acting for a payer under contract from using a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system in lieu of a paper form, provided that it is consistent with the paper form, developed pursuant to subsection (c).

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

(1) not exceed 2 pages;

(2) be made electronically available; and

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

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

(1) seek input from interested stakeholders and shall seek to use forms that have been mutually agreed upon by payers and providers;

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

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

(f) Nothing in this section shall limit a health plan from requiring prior authorization for services.

Section 26. The commissioner shall establish standardized processes and procedures applicable to all health care providers and payers for the determination of a patient's health benefit plan eligibility at or prior to the time of service. As part of such processes and procedures, the commissioner shall (i) require payers to implement automated approval systems such as decision support software in place of telephone approvals for specific types of services specified by the commissioner and (ii) require establishment of an electronic data exchange to allow providers to determine eligibility at or prior to the point of care.

Section 27. The division shall develop a common summary of payments form to be used by all health care payers in the commonwealth that is provided to health care consumers with respect to provider claims submitted to a payer and written in an easily readable and understandable format showing the consumer's responsibility, if any, for payment of any portion of a health care provider claim; provided that the division shall allow the development of forms to be exchanged through electronic means. The division shall consult with stakeholders to develop these forms.

SECTION 208. Section 1 of chapter 176Q of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after the definition of "Connector seal of approval" the following definition:-

"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.

SECTION 209. Said section 1 of said chapter 176Q, as so appearing, is hereby further 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.

"Non-providing employer", an employer of a state-funded employee, as defined in this section; provided, however, that the term "non-providing employer" shall not include: (i) an employer who complies with chapter 151F for such employee; (ii) an employer that is signatory to or obligated under a negotiated, bona fide collective bargaining agreement between such employer and bona fide employee representative which agreement governs the employment conditions of such person receiving free care; (iii) an employer who participates in the insurance reimbursement program; or (iv) an employer that employs not more than 10 employees; provided, further, that for the purposes of this definition, an employer shall not be considered to pay for or arrange for the purchase of health care services provided by acute hospitals and ambulatory surgical centers by making or arranging for any payments to the uncompensated care pool.

SECTION 212. Said section 1 of said chapter 176Q, as so appearing, is hereby further amended by inserting after the definition of "Participating institution" the following definition:-

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

SECTION 213. Said section 1 of said chapter 176Q is hereby further amended by inserting after the definition of "Stand-alone vision plan", inserted by section 39 of chapter 118 of the acts of 2012, the following definition:-

"State-funded employee", any employed person, or dependent of such person, who receives, on more than 3 occasions during any hospital fiscal year, health services paid for as free care; or any employed persons, or dependents of such persons, of a company that has 5 or more occurrences of health services paid for as free care by all employees in aggregate during any

fiscal year; provided, that an occurrence shall include all healthcare related services incurred during a single visit to a health care professional.

SECTION 214. Said section 1 of said chapter 176Q, as appearing in the 2010 Official Edition, is hereby further amended by adding the following definition:-

"Uninsured patient", a patient who is not covered by a health insurance plan, a self-insurance health plan or a medical assistance program.

SECTION 215. Said chapter 176Q is hereby further amended by adding the following 2 sections:—

Section 17. (a) The connector shall prepare a form, to be called the employer health insurance responsibility disclosure, on which an employer shall report whether it is in compliance with chapter 151F and any other information required by the connector relative to section 18 and paragraph (4) of subsection (a) of section 69 of chapter 118E. The form shall be completed, signed and returned to theconnector by every employer with 11 or more full-time equivalent employees.

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

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

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

(b) The amount of the free rider surcharge on non-providing employers shall be determined by the authority under regulations promulgated by the authority, and assessed by the authority not later than 3 months after the end of each hospital fiscal year, with payment by non-providing employers not later than 180 days after the assessment. The amount charged by the authority shall be greater than 10 per cent but not greater than 100 per cent of the cost to the state of the services provided to the state-funded employee, considering all payments received by the state from other financing sources for free care; provided, that the “cost to the state” for services provided to any state-funded employee may be determined by the authority as a percentage of the state’s share of aggregate costs for health services. The free rider surcharge shall only be triggered upon incurring $50,000 or more, in any hospital fiscal year, in free care services for any employer’s employees, or dependents of such persons, in aggregate, regardless of how many state-funded employees are employed by that employer.

(c) The formula for assessing free rider surcharges on non-providing employers shall be set forth in regulations promulgated by the authority that shall be based on factors including, but not limited to: (i) the number of incidents during the past year in which employees of the non-providing employer received services reimbursed by the health safety net office under section 69 of chapter 118E; (ii) the number of persons employed by the non-providing employer; and (iii) the proportion of employees for whom the non-providing employer provides health insurance.

(d) If a state-funded employee is employed by more than 1 non-providing employer at the time the state-funded employee receives services, the authority shall assess a free rider surcharge on each said employer consistent with the formula established by the authority under this section.

(e) The authority shall specify by regulation appropriate mechanisms for implementing free rider surcharges on non-providing employers. Said regulations shall include, but not be limited to, the following provisions: (i) appropriate mechanisms that provide for determination and payment of the surcharge by a non-providing employer including requirements for data to be submitted by employers, employees, acute hospitals and ambulatory surgical centers, and other persons; and (ii) penalties for nonpayment or late payment by the non-providing employer, including 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.

(f) All surcharge payments made under this section shall be deposited into the Commonwealth Care Trust Fund, established under section 2OOO of chapter 29.

(g) A non-providing employer's liability to the Commonwealth Care Trust Fund shall, in the case of a transfer of ownership, be assumed by the successor in interest to the non-providing employer's interest.

(h) If a non-providing employer fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the authority, the authority shall provide written notice of the required information. If the employer fails to provide information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject to a civil penalty of not more than $5,000 for each week on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction.

(i) The attorney general shall bring any appropriate action, including injunctive relief, as may be necessary for the enforcement of this chapter.

(j) No employer shall discriminate against any employee on the basis of the employee's receipt of free care, the employee's reporting or disclosure of the employer's identity and other information about the employer, the employee's completion of a Health Insurance Responsibility Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed against the employer in relation to the employee. Violation of this subsection shall constitute a per se violation of chapter 93A.

(k) A hospital, surgical center, health center or other entity that provides uncompensated care pool services shall provide an uninsured patient with written notice of the criminal penalties for committing fraud in connection with the receipt of uncompensated care pool services. The 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.

"Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.

"Nondiscriminatory basis", a carrier shall be deemed to be providing coverage on a non-discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a physician assistant which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other participating providers.

"Participating provider", a provider who, under terms and conditions of a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to an insured with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the carrier.

"Physician assistant", a person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician in accordance with sections 9C to 9H, inclusive, of chapter 112, and who has passed the Physician Assistant National Certifying Exam or its equivalent.

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

Section 2. The commissioner and the group insurance commission shall require that all carriers recognize physician assistants as participating providers subject to section 3 and shall include coverage on a nondiscriminatory basis to their insureds for care provided by physician

assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a physician assistant who is a participating provider and is practicing within the scope of his or her professional authority as defined by statute, rule and physician delegation to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.

Section 3. A participating provider physician assistant practicing within the scope of such physician assistant's license, including all regulations requiring collaboration with or supervision by a physician under section 9E of chapter 112, shall be considered qualified within the carrier's definition of primary care provider to an insured.

Section 4. Notwithstanding any general or special law to the contrary, a carrier that requires the designation of a primary care provider shall provide its insured with an opportunity to select a participating provider physician assistant as a primary care provider.

Section 5. Notwithstanding any general or special law to the contrary, a carrier shall ensure that all participating provider physician assistants are included on any publicly accessible list of participating providers for the carrier.

Section 6. A complaint for noncompliance against a carrier shall be filed with and investigated by the commissioner or the group insurance commission, whichever shall have regulatory authority over the carrier. The commissioner and the group insurance commission shall promulgate regulations to enforce this chapter.

CHAPTER 176T

RISK-BEARING PROVIDER ORGANIZATIONS

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

"Alternative payment contract", any contract between a provider or provider organization and a health care payer payer which utilizes alternative payment methodologies.

"Alternative payment methodologies or methods", methods of payment that are not solely based on fee-for-service reimbursements; provided, however, that "alternative payment methodologies" may include, but shall not be limited to, shared savings arrangement, bundled payments, and global payments; and further provided, that "alternative payment methodologies" may include fee-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, but not including 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, however, 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 vision care services.

"Center", the center for health information and analysis established in chapter 12C.

"Commission", the health policy commission established in chapter 6D.

"Commissioner", the commissioner of insurance.

"Division", the division of insurance.

"Downside risk", the risk taken on by a provider organization as part of an alternate payment contract with a carrier or other payer in which the provider organization is responsible for either the full or partial costs of treating a group of patients that may exceed the contracted budgeted payment arrangements.

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

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

"Medicaid program", the medical assistance program administered by the office of Medicaid under chapter 118E and in accordance with Title XIX of the Federal Social Security Act or any successor statute.

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

"Medical service corporation", a corporation established to operate a nonprofit medical service plan as provided in chapter 176B.

"Medicare program", the medical insurance program established by Title XVIII of the Social Security Act.

"Provider" or "health care provider", any person, corporation, partnership, governmental unit, state institution or any other entity qualified under the laws of the commonwealth to perform or provide health care services.

"Provider organization", any corporation, partnership, business trust, association or organized group of persons in the business of health care delivery or management whether incorporated or not that represents 1 or more health care providers in contracting with carriers for the payments of heath care services; provided, however, 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 the

provisions of 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.

"Registered provider organization", a provider organization that has been registered in accordance with chapter 6D.

"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.

"Risk certificate", a certificate of solvency issued by the division of insurance.

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

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

Section 2. Except as hereinafter provided, a risk-bearing provider organization shall not be subject to chapters 175, 176A, 176B, 176C, 176E, 176F, 176G and 176J; provided, however, that a risk-bearing provider organization that enters into a contract with employers or individuals under which the provider organization would assume a significant portion of downside risk, as defined through division regulations, may be subject to the provisions of said chapters 175, 176A, 176B, 176C, 176E, 176F, 176G and 176J for the purposes of such contracts.

Section 3. (a) Each registered provider organization that enters into or renews an alternative payment contract with a carrier or public health care payer in which the provider organization accepts downside risk shall file an application for a risk certificate with the division; provided, however, that integrated care organizations or senior care organizations contracted under section 9D or 9E of chapter 118E which have undergone a financial solvency certification shall be deemed to be to have satisfied the risk certificate requirements for purposes of this chapter.

(b) A risk-bearing provider organization may apply for a risk certificate waiver if it wishes to demonstrate that its alternative payment contracts do not contain significant downside risk. A risk-bearing provider organization may be deemed to be in compliance with the division's standards if the division determines that the provider organization's alternative payment contracts do not contain significant downside risk. The division shall forward such waiver in writing to the commission and the center.

(c) The applicant for a risk certificate shall file such information as the commissioner shall by regulation require, in a form approved by the commissioner. A risk-bearing provider organization shall make an annual filing to renew its risk certificate. Such information shall include, but not be limited to:

(1) the filing materials submitted to be registered as a provider organization, pursuant to chapter 6D;

(2) a list of all carriers and public health payers with which the provider organization has entered into alternative payment contracts with downside risk;

(3) financial statements showing the risk-bearing provider organization's assets, liabilities, reserves and sources of working capital and other sources of financial support and projections of the results of operations for the succeeding 3 years;

(4) a financial plan, including a statement indicating the anticipated timing for receipt of income from alternative payment contracts with downside risk versus the incurrence of expenses, a statement of the applicant's plan to establish and maintain sufficient reserves or other resources that will protect the risk-bearing provider organization from the potential losses from downside risk, copies of insurance or other agreements which protect the risk-bearing provider organization from potential losses from downside risk, and a detailed description of mechanisms to monitor the financial solvency of any provider organization subcontracting with the applicant that assumes downside risk in its alternative payment arrangement with the risk-bearing provider organization;

(5) a utilization plan describing the methods by which the risk-bearing provider organization will monitor inpatient and outpatient utilization under the alternative payment contracts with downside risk;

(6) an actuarial certification that, after examining the terms of all the risk-bearing provider organization's alternative payment contracts with downside risk that the alternate payment contracts are not expected to threaten the financial solvency of the risk-bearing provider organization; and

(7) such other information as the division may specify through regulation.

(d) There shall be a fee for such application or renewal, in an amount determined by the 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.

Upon receipt of the verified report, the commissioner shall transmit the report to the risk-bearing provider organization examined together with a notice which shall afford the risk-bearing provider organization examined a reasonable opportunity of not more than 30 days to make a written submission or rebuttal with respect to any matters contained in the examination report. Within 30 days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall consider and review the reports together with any written submissions or rebuttals and any relevant portions of the examiner's work papers and enter an order:

(i) adopting the examination report as filed with modifications or corrections and, if the examination report reveals that the risk-bearing provider organization is operating in violation of this section or any regulation or prior order of the commissioner, the commissioner may order the risk-bearing provider organization to take any action the commissioner considered necessary and appropriate to cure such violation;

(ii) rejecting the examination report with directions to examiners to reopen the examination for the purposes of obtaining additional data, documentation or information and re-filing pursuant to the above provisions; or

(iii) calling for an investigatory hearing with no less than 20 days notice to the risk-bearing provider organization for purposes of obtaining additional documentation, data, information and testimony.

(f) Notwithstanding any other General Law to the contrary, including clause Twenty-sixth of section 7 of chapter 4 and chapter 66, the records of any such audit, examination or other inspection and the information contained in the records, reports or books of any risk-bearing

provider organization examined pursuant to this section shall be confidential and open only to the inspection of the commissioner, or the examiners and assistants. Access to such confidential material may be granted by the commissioner to law enforcement officials of the commonwealth or any other state or agency of the federal government at any time, so long as the agency or office receiving the information agrees in writing to hold such material confidential. Nothing herein shall be construed to prohibit the required production of such records, and information contained in the reports of such company or organization before any court of the commonwealth or any master or auditor appointed by any such court, in any criminal or civil proceeding, affecting such risk-bearing provider organization, its officers, partners, directors or employees. The final report of any such audit, examination or any other inspection by or on behalf of the division of insurance shall be a public record.

Section 5. (a) If upon examination or at any other time the commissioner determines that the risk-bearing provider organization's existing or proposed alternative payment contracts with downside risk are likely to threaten the financial solvency of the risk-bearing provider organization, the commissioner shall provide notice to the risk-bearing provider organization.

(b) The commissioner may suspend, cancel, non-renew or refuse to issue a risk-bearing provider organization's risk certificate upon a determination that the risk-bearing provider organization has not cured a threat to financial solvency, that the risk-bearing provider organization's application for a risk certificate is incomplete or contains or is based on fraudulent information, or that the risk-bearing provider organization has otherwise failed to comply with the requirements of this chapter. The commissioner shall notify the risk-bearing provider organization and advise, in writing, of the reason for any refusal to issue or non-renew a risk certificate under this chapter. A copy of the notice shall be forwarded to the commission and

center. The applicant or certified risk-bearing provider organization may make written demand upon the commissioner within 30 days of receipt of such notification for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held pursuant to chapter 30A.

(c) The commissioner shall not suspend or cancel a risk certificate unless the commissioner has first afforded the risk-bearing provider organization an opportunity for a hearing pursuant to chapter 30A.

(d) Upon a ruling by the commissioner to suspend or cancel a risk-bearing provider organization's certification, a written notice shall be forwarded to the commission and the center.

Section 6. (a) For purposes of this section, "health care provider" shall mean any physician, hospital or other person or entity furnishing health services that has contracted to provide services according to its agreements with a risk-bearing provider organization.

(b) A health care provider or any representative of a health care provider shall not maintain any action against a patient to collect or attempt to collect any money owed to the health care provider by a risk-bearing provider organization.

(c) A risk-bearing provider organization shall include provisions within its contracts with health care providers that conspicuously prohibit health care providers from collecting or attempting to collect money from a patient that is owed to the health care provider by a risk-bearing provider organization.

Section 7. All information provided by risk-bearing provider organizations to the division under this chapter shall be made available to the center and the commission.

Section 8. Nothing in this chapter shall exempt any person from any applicable provisions of chapter 111, 112 or 176T including, but not limited to, provisions relating to determination of need, licensure and regulation of hospitals and clinics and registration of health professionals.

Section 9. The commissioner shall promulgate rules and regulations as are necessary to carry out the provisions of this chapter. In developing the rules and regulations, including risk-bearing standards, certification and reporting requirements, the commissioner shall consider other rules and regulations applicable to such organizations and shall consult with the center and the commission regarding standards concerning provider organizations which enter into alternative payment contracts.

SECTION 218. Section 8A of chapter 180 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 100 and 101, the words "division of health care finance and policy pursuant to chapter 118G" and inserting in place thereof the following words:- center for health information and analysis under chapter 12C.

SECTION 219. Section 9 of chapter 209C of the General Laws is hereby amended by striking out, in lines 36 and 37, as so appearing, the words "the division of medical assistance or division of health care finance and policy" and inserting in place thereof the following words:- the office of Medicaid or the executive office of health and human services.

SECTION 220. Section 60K of chapter 231 of the General Laws, as so appearing, is hereby amended by striking out, in line 14, the figure "4" and inserting in place thereof the following figure:- 2.

SECTION 221. Said chapter 231 is hereby further amended by inserting after section 60K the following section:-

Section 60L. (a) Except as otherwise provided in this section, a person shall not commence an action against a provider of health care as defined in the seventh paragraph of section 60B unless the person has given the health care provider 182 days written notice before the action is commenced.

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

(c) The 182-day notice period in subsection (a) shall be shortened to 90 days if:

(1) the claimant has previously filed the 182-day notice required against another health care provider involved in the claim; or

(2) the claimant has filed a complaint and commenced an action alleging medical malpractice against any health care provider involved in the claim.

(d) The 182 day notice of intent required in subsection (a) shall not be required if the claimant did not identify and could not reasonably have identified a health care provider to which notice shall be sent as a potential party to the action before filing the complaint;

(e) The notice given to a health care provider under this section shall contain, but shall not be limited to, a statement including:

(1) the factual basis for the claim;

(2) the applicable standard of care alleged by the claimant;

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

(4) the alleged action that should have been taken to achieve compliance with the alleged standard of care;

(5) the manner in which it is alleged the breach of the standard of care was the proximate cause of the injury claimed in the notice; and

(6) the names of all health care providers that the claimant intends to notify under this section in relation to a claim.

(f) Not later than 56 days after giving notice under this section, the claimant shall allow the health care provider receiving the notice access to all of the medical records related to the claim that are in the claimant's control and shall furnish a release for any medical records related to the claim that are not in the claimant's control, but of which the claimant has knowledge. This subsection shall not restrict a patient's right of access to the patient's medical records under any other law.

(g) Within 150 days after receipt of notice under this section, the health care provider or authorized representative against whom the claim is made shall furnish to the claimant or the claimant's authorized representative a written response that contains a statement including the following:

(1) the factual basis for the defense, if any, to the claim;

(2) the standard of care that the health care provider claims to be applicable to the action;

(3) the manner in which it is claimed by the health care provider that there was or was not compliance with the applicable standard of care; and

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

(h) If the claimant does not receive the written response required under subsection (g) within the required 150-day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 150-day time period. If a provider fails to respond within 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other means then interest on any judgment against that provider shall accrue and be calculated from the date that the notice was filed rather than the date that the suit is filed. At any time before the expiration of the 150-day period, the claimant and the provider may agree to an extension of the 150-day period.

(i) If at any time during the applicable notice period under this section a health care provider receiving notice under this section informs the claimant in writing that the health care provider does not intend to settle the claim within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health care provider, so long as the claim is not barred by the statutes of limitations or repose.

(j) A lawsuit against a health care provider filed within 6 months of the statute of limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any claimant, shall be exempt from compliance with this section.

(k) Nothing in this section shall prohibit the filing of suit at any time in order to seek court orders to preserve and permit inspection of tangible evidence.

SECTION 222. Section 85K of said chapter 231, as appearing in the 2010 Official Edition, is hereby amended by inserting after the word "costs", in line 8, the following words:- ; and provided further, that in the context of medical malpractice claims against a nonprofit organization providing health care, such cause of action shall not exceed the sum of $100,000, exclusive of interest and costs.

SECTION 223. Chapter 233 of the General Laws is hereby amended by inserting after section 79K the following section:-

Section 79L. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

"Facility", a hospital, clinic, or nursing home licensed under chapter 111, a psychiatric facility licensed under chapter 19 or a home health agency; provided, however, that "facility" shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority or other entity comprised of such facilities.

"Health care provider", any of the following health care professionals licensed under chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, dental hygienist, optometrist, nurse, nurse practitioner, physician assistant, chiropractor, psychologist,

independent clinical social worker, speech-language pathologist, audiologist, marriage and family therapist or mental health counselor; provided, however, that “health care provider” shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such health care providers.

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

(b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, all statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error or a general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative proceeding, unless the maker of the statement, or a defense expert witness, when questioned under oath during the litigation about facts and opinions regarding any mistakes or errors that occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in which case the statements and opinions made about the mistake or error shall be admissible for all purposes. In situations where a patient suffers an unanticipated outcome with significant medical complication resulting from the provider’s mistake, the health care provider, facility or an employee or agent of a health care provider or facility shall fully inform the patient and, when appropriate, the patient's family, about said unanticipated outcome.

SECTION 224. Clause (2) of subsection (b) of section 3 of chapter 258C of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out subclause (A) and inserting in place thereof the following subclause:-

(A) Expenses incurred for hospital services as the direct result of injury to the victim shall be compensable under this chapter; provided, however, that when claiming compensation for hospital expenses, the claimant shall demonstrate an out-of-pocket loss or a legal liability for payment of said expenses. No hospital expenses shall be paid if the expense is reimbursable by Medicaid or if the services are covered by chapter 118E. Every claim for compensation for hospital services shall include a certification by the hospital that the services are not reimbursable by Medicaid and that the services are not covered by chapter 118E. In no event shall the amounts awarded for hospital services exceed the rates for services established by the executive office of health and human services or a governmental unit designated by the executive office if rates have been established for such services.

SECTION 225. Section 62 of chapter 177 of the acts of 2001 is hereby amended by inserting after the word “commission”, in line 2, the following words: - , the executive director of the commonwealth health insurance connector authority.

SECTION 226. The first paragraph of section 271 of chapter 127 of the acts of 1999 is hereby amended by inserting after the word “affairs”, in line 3, the following words:- , the executive director of the commonwealth health insurance connector authority.

SECTION 227. Said first paragraph of said section 271 of said chapter 127 is hereby further amended by striking out clause (i) and inserting in place thereof the following words:- (i) enrollees in Commonwealth Care under chapter 176Q of the General Laws.

SECTION 228. Section 16 of chapter 257 of the acts of 2008, as amended by section 27 of chapter 9 of the acts of 2011, is hereby further amended by striking out the words "section 7 of chapter 118G" and inserting in place thereof the following words:- section 13D of chapter 118E.

SECTION 229. Section 17 of said chapter 257, as most recently amended by section 28 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words "7 of chapter 118G" and inserting in place thereof the following words:- 13D of chapter 118E.

SECTION 230. Section 18 of said chapter 257, as amended by section 29 of said chapter 9, is hereby further amended by striking out the words "section 7 of chapter 118G" and inserting in place thereof the following words:- "section 13D of chapter 118E.

SECTION 231. Section 15 of chapter 305 of the acts of 2008 is hereby repealed.

SECTION 232. Section 31 of chapter 288 of the acts of 2010 is hereby repealed.

SECTION 233. Section 54 of said chapter 288 is hereby repealed.

SECTION 234. Said chapter 288 is hereby further amended by striking out section 66 and inserting in place thereof the following section:—

Section 66. For small group base rate factors applied under section 3 of chapter 176J of the General Laws between October 1, 2010 and July 1, 2015, a carrier shall limit the effect of the application of any single or combination of rate adjustment factors identified in clauses (2) to (6), inclusive, of subsection (a) of said chapter 3 of said chapter 176J that are used in the calculation of an individual's or small group's premium so that the final annual premium charged to an

individual or small group does not increase by more than an amount established annually by the commissioner by regulation.

SECTION 235. Section 70 of said chapter 288 is hereby repealed.

SECTION 236. The first sentence of section 48 of chapter 9 of the acts of 2011 is hereby amended by striking out the words "7 of chapter 118G" and inserting in place thereof the following words:- 13D of chapter 118E.

SECTION 237. Notwithstanding any general or special law to the contrary, no provision of this act shall be construed to impair or in any way modify the authority of the executive office of health and human services to act, pursuant to section 16 of chapter 6A of the General Laws, as the single state agency authorized to supervise and administer the state programs under titles XIX and XXI of the Social Security Act.

SECTION 238. The commissioner of revenue, in consultation with the department of public health and the office of commonwealth performance, accountability and transparency, shall review the wellness program tax credit in section 6N of chapter 62 of the General Laws and section 38FF of chapter 63 of the General Laws and report on whether this tax credit achieved the desired outcome and stated public policy purpose of the tax credit and if the tax credit is the most cost effective means of achieving this public policy purpose and whether the tax credit should be subject to a recapture if certain conditions are not met. The commissioner shall file a report, together with any recommendations regarding whether there should be legislative changes to the tax credit or whether the goals of the tax credit can better be served through other means, to the governor and to the clerks of the house and senate who shall forward the same to the joint

committee on revenue, the joint committee on health care financing, and the house and senate ways and means committees not later than January 1, 2017.

SECTION 239. Notwithstanding any general or special law to the contrary, the commissioner of revenue, in consultation with the department of public health, shall authorize annually an amount not to exceed $15,000,000 for the wellness program tax credit in section 6N of chapter 62 of the General Laws together with chapter 38FF of chapter 63 of the General Laws.

SECTION 240. (a) The health information technology council, established in section 2 of chapter 118I of the General laws, shall conduct an evaluation of the effectiveness of its expenditures under section 10 of said chapter 118I, and the Massachusetts e-health institute shall conduct an evaluation of the effectiveness of expenditures authorized under section 6D of chapter 40J of the General Laws and each shall submit a report thereon.

(b) The reports by the council and the institute shall include an analysis of all relevant data so as to determine the effectiveness and return on investment of funding under section 6D of said chapter 40J and section 10 of chapter 118I. The reviews by the council and the institute shall each include specific findings and legislative recommendations including the following:-

(1) to what extent their respective programs increased the adoption of interoperable electronic health records, including to what extent those programs increased the adoption of interoperable electronic health records for providers;

(2) to what extent their respective programs reduced health care costs or the growth in health care cost trends on a provider-based net cost and health plan based premium basis, including an analysis of what entities benefitted from, or were disadvantaged by, any cost reductions and the specific impact of the funding mechanism;

(3) to what extent their respective programs increased the number of health care providers in achieving and maintaining compliance with the standards for meaningful use, beyond stage 1, established by the United States Department of Health and Human Services;

(4) to what extent their respective programs should be discontinued, amended or expanded and, if so, a timetable for implementation of the recommendations; and

(5) to what extent additional public funding is needed for the implementation of their respective programs.

(c) To the extent possible, the council and the institute shall obtain and use actual health plan data from the all-payer claims database as administered by the center for health information and analysis, but such data shall be confidential and shall not be a public record for any purpose.

(d) The council and the institute shall report the results of their reviews and recommendations, if any, together with drafts of legislation necessary to carry out such recommendations by March 31, 2016. The report shall be provided 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 posted on the council's and the institute's websites.

SECTION 241. (a). Notwithstanding any special or general law to the contrary, the health policy commission shall establish a one-time surcharge assessment on all acute hospitals satisfying the requirements of subsection (b) to be deposited according to the requirements of subsection (f). The surcharge amount to be paid by each acute hospital shall equal the product of: (i) the surcharge percentage; and (ii) $60,000,000. The commission shall calculate the surcharge percentage by dividing the operating surplus in fiscal year 2010 by the total operating surplus in fiscal year 2010 of all acute hospitals paying an assessment under this section. The

commission shall determine the surcharge percentage for the assessment by December 31, 2012. In the determination of the surcharge percentage, the commission shall use the best data available as determined by the commission and may consider the effect on projected surcharge payments of any modified or waived enforcement pursuant to subsection (c). The commission shall incorporate all adjustments, including, but not limited to, updates or corrections or final settlement amounts, by prospective adjustment rather than by retrospective payments or assessments.

(b) Only acute hospitals or acute hospital systems with more than $1,000,000,000 in total net assets and less than 50 per cent of revenues from public payers shall be subject to the assessment. The commission may waive the assessment for certain acute hospitals, if the commission reasonably determines the hospital or hospital system lacks access to resources available to pay the assessment. The commission shall make a determination for waiver based on the following factors: (A) cash and investments on hand; (B) total revenues; (C) total cash and investments; (D) total reserves; (E) total profits, margins or surplus; (F) earnings before interest, depreciation and amortization; (G) administrative expense ratio; and (H) the compensation of executive managers and board members.

(c) The commission may provide assessment mitigation up to 66 per cent of the surcharge assessment if an assessable provider meets either of the following:

(1) any acute hospital or acute hospital system that receives more than 25 per cent of its reimbursements from Title XIX of the Social Security Act; or

(2) any acute hospital or acute hospital system whose net assets do not exceed $1,250,000,000.

(d) Surcharge payors shall be assessed a surcharge to be paid to the commission in accordance with the provisions of subsection (e). The surcharge amount shall equal the product of: (i) the surcharge percentage; and (ii) $165,000,000. The commission shall calculate the surcharge percentage by dividing the surcharge payor's payments for acute hospital services by the total payments for acute hospital services by all surcharge payors. The commission shall determine the surcharge percentage for the assessment by December 31, 2012. In the determination of the surcharge percentage, the commission shall use the best data available as determined by the commission and may consider the effect on projected surcharge payments of any modified or waived enforcement pursuant to subsection (c). The commission shall incorporate all adjustments, including, but not limited to, updates or corrections or final settlement amounts, by prospective adjustment rather than by retrospective payments or assessments.

(e) Acute hospitals and surcharge payors shall pay the full amount of the surcharge amount as follows:

(1) a single payment to be made no later than June 30, 2013; or

(2) in 4 equal annual installments to be paid on or before June 30 of each year beginning on June 30, 2013.

(f) The assessment shall be distributed as follows by the comptroller as such assessments are collected:

(1) 60 per cent, for a 4-year a total of $135,000,000 to the Distressed Hospital Trust Fund, established in section 2GGGG of chapter 29 of the General Laws; provided,

however, that any reduced assessment under subsections (b) or (c) shall reduce this amount;

(2) 26 and 2/3 per cent, for a 4-year total of $60,000,000, to the Prevention and Wellness Trust Fund, established in section 2G of chapter 111 of the General Laws; and

(3) 13 and 1/3 per cent, for a 4-year total of $30,000,000 to the e-Health Institute Fund established in section 6E of chapter 40J.

Prior to depositing the assessment in these funds, the comptroller shall deduct 5 per cent of each amount set forth in this subsection and transfer it to the Health Care Payment Reform Fund established in section 100 of chapter 194 of the acts of 2011 for the administration of the health policy commission.

Deposits to the Prevention and Wellness Trust Fund and the e-Health Institute Fund shall not be reduced due to any waiver authorized by the commission under subsections (b) or (c). The total amount waived shall be reduced from the amount to be deposited in the Distressed Hospital Trust Fund.

(g) The commission shall specify by regulation appropriate mechanisms that provide for determination and payment of an acute hospital, or a surcharge payor's liability, including requirements for data to be submitted by acute hospitals andsurcharge payors.

(h) A hospital's liability to the fund shall in the case of a transfer of ownership be assumed by the successor in interest to the hospital.

(i) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be 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

payor. If an acute hospital or surcharge payor fails to provide required information within 14 days after the receipt of written notice, or falsifies the same, such hospital or payor shall be subject to a civil penalty of not more than $5,000 for each day on which the violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction. The attorney general shall bring any appropriate action, including injunctive relief, necessary for the enforcement of this chapter.

(l) Acute hospitals shall not seek an increase in rates to pay for this assessment.

(m) Surcharge payors shall not seek an increase in premiums to pay for this assessment.

SECTION 242. Notwithstanding any general or special law to the contrary, to the extent permitted by federal law, every third-party administrator shall disclose to their self-insured or self-funded employer group health plan clients the contracted prices of services of in-network providers.

SECTION 243. Any provider organization certified as an accountable care organization or a patient-centered medical home under chapter 6D of the General Laws and any risk-bearing provider organization shall have an interoperable electronic medical record system available for participants to coordinate care, share information and prescribe electronically by December 31, 2016.

SECTION 244. Notwithstanding any general or special law or rule or regulation to the contrary, the health care workforce center shall investigate the possibility of dedicating funds for joint appointments for clinicians with clinical agencies and universities. As part of the arrangement, clinicians pursuing doctoral education would receive tuition and fee reimbursement

for maintaining a clinical position and teaching at the entry level of the academic program while pursuing their doctoral degree.

SECTION 245. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall seek from the secretary of the United States Department of Health and Human Services an exemption or waiver from the Medicare requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing facility be preceded by a 3-day hospital stay.

SECTON 246. Notwithstanding any general or special law to the contrary, the office of Medicaid shall not terminate the coverage of any commonwealth care recipient, if: the office has requested documentation, including the eligibility review form; the recipient has provided such documentation on or before the date the office stated, in writing, that such documentation was to be submitted; and the office has acknowledged receipt of the documentation, until the office determines the eligibility for benefits based on the submitted information. The director of the office of Medicaid shall promulgate regulations to ensure the proper implementation of this section.

SECTION 247. The secretary of administration and finance and the secretary of health and human services shall evaluate the feasibility of contracting for recycling durable medical equipment purchased and issued by the commonwealth through any and all of its medical assistance programs.

Said evaluation shall include, but not be limited to, a request for qualifications or proposals from entities capable of developing, implementing and operating a system of recycling whereby an inventory of such equipment is developed and managed so as to maximize the

quality of service delivery to equipment recipients and to minimize costs and losses attributable to waste, fraud or abuse.

The secretary of administration and finance shall report the findings of the evaluation, together with cost estimates for the operation of a recycling program, estimates of the savings it would generate and legislative recommendation to the clerks of the house of representatives and the senate, one joint committee on health care financing, the house committee on ways and means and the senate committee on ways and means, not later than October 31, 2013.

SECTION 248. Notwithstanding any general or special law to the contrary, the office of Medicaid and the department of unemployment assistance shall, in consultation with the executive office of health and human services, develop and implement a means by which the office of Medicaid may access information as to the status of or termination of unemployment benefits and the associated insurance coverage by the medical security plan, as administered by the executive office of labor and workforce development, for the purposes of determining eligibility for those individuals applying for benefits through health care insurance programs administered by the executive office of health and human services. The office and the department shall implement this system not later than February 1, 2013; provided, however, that if legislative action is required prior to implementation, recommendations for such action shall be filed with the clerks of the house of representatives and the senate and the joint committee on health care financing not later than January 1, 2013.

SECTION 249. Notwithstanding any general or special law to the contrary, the division of insurance, in consultation with the board of registration in medicine, shall conduct a report on the potential for out-of-state physicians to practice telemedicine in the commonwealth. The

report shall review the following: (i) licensure or authorization to practice medicine by an out-of-state physician; (ii) reimbursement of telemedicine services performed by out-of-state physicians; (iii) patient cost sharing responsibilities of telemedicine services performed by out-of-state physicians; (iv) any liability concerns associated with an out-of-state physician practicing medicine in the commonwealth, and the ability of patients to pursue medical malpractice claims; (v) the ability for out-of-state physicians to maintain an interoperable electronic health record; and (vi) the ability of out-of-state physicians to meet meaningful use standards associated with the commonwealth's health information exchange. To the extent possible, the division shall review and report on any national or regional licensure standards that exist or are being considered, and their implications on licensure of out-of-state physicians in the commonwealth. The report shall include recommendations for legislation to permit the use of out-of-state physicians for telemedicine. The report shall be submitted to clerks of the house of representatives and the senate, and the joint committees on health care financing and financial services by July 1, 2013.

SECTION 250. Notwithstanding any special or general law to the contrary, the executive office of health and human services, in collaboration with the department of veterans' services and the office of Medicaid shall study methods to improve access to Department of Veterans' Affairs benefits for qualified veterans, survivors and dependents currently enrolled in the MassHealth program. The study shall include, but not be limited to: (i) identifying barriers to assisting these individuals in obtaining federal veteran health care benefits; and (ii) an examination of the feasibility, costs and benefits of utilizing the federal public assistance reporting information system (PARIS) to identify veterans and their dependents or surviving spouses who are enrolled in the MassHealth program. The study shall also examine the process

and any projected information technology costs of exchanging information with the federal public assistance reporting information system. If the executive office of health and human services determines that the financial benefits outweigh the costs of utilizing the federal public assistance reporting information system, the executive office of health and human services shall be authorized to enter into any agreements and undertake such other measures as necessary to utilize such system to identify eligible veterans, dependents and survivors. The executive office may also, if it determines that the benefits outweigh the costs, enter into an agreement with the department of veterans' services to perform veterans outreach services to assist qualified veterans, survivors and dependents in obtaining benefits. Any such agreement shall contain performance standards that will allow the secretary of health and human services to measure the effectiveness of the program established by this section. The secretary of health and human services shall report the findings of this study and any actions taken pursuant this section to the joint committee on veterans and federal affairs, the joint committee on health care financing, and the house and senate committees on ways and means not later than April 1, 2013.

SECTION 251. Notwithstanding any general or special law to the contrary, the office of the state auditor shall conduct a comprehensive review of the impact of this act on the health care payment and delivery system in the commonwealth and on health care consumers, the health care workforce and general public.

The review shall include, but not be limited to, an investigation of:

(1) The impact on health care costs, including the extent to which savings have reduced out-of-pocket costs to individuals and families, health insurance premium costs and health care costs borne by the commonwealth;

(2) The impact on access to health care services and quality of care in different regions of the state and for different populations, particularly for children, the elderly, low-income individuals, individuals with disabilities and other vulnerable populations;

(3) The impact on access and quality of care for specific services, particularly primary care, behavioral, substance use disorder and mental health services;

(4) The impact on the health care workforce, including, but not limited to, health care worker recruitment and retention, health care worker shortages, training and education requirements and job satisfaction; and

(5) The impact on public health, including, but not limited to, reducing the prevalence of preventable health conditions, improving employee wellness and reducing racial and ethnic disparities in health outcomes.

The office of the state auditor shall, to the extent possible, obtain and use data from the center for health information and analysis, the health policy commission, and the department of public health to conduct its analysis; provided, however, that such data shall be confidential and shall not be a public record under clause twenty-sixth of section 7 of chapter 4 of the General Laws. The office of the state auditor may contract with an outside organization to conduct this review.

The office of the state auditor shall report the results of such review and its recommendations, if any, together with drafts of legislation necessary to carry out such recommendations to the house and senate committees on ways and means and the joint committee on public health and post the results on the state auditor's website not later than March 31, 2017.

SECTION 252. Nothing in this act shall be construed to preclude an individual from obtaining additional insurance or paying out of pocket for any medical service not covered by the individual's health plan.

SECTION 253. Notwithstanding any general or special law to the contrary, the executive office of health and human services shall require Medicaid, any carrier or other entity which contracts with the office of Medicaid to pay for or arrange for the purchase of health care services, the commonwealth care health insurance program established under chapter 118H of the General Laws, any carrier or other entity which contracts with the commonwealth care health insurance program to pay for or arrange for the purchase of health care services, and any other state sponsored or state managed plan providing health care benefits to reimburse any licensed hospital facility operating in the commonwealth that has been designated as a critical access hospital under U.S.C. 1395i-4, in an amount equal to at least 101 per cent of allowable costs under each such program, as determined by utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services.

SECTION 254. Notwithstanding any general or special law, or rule or regulation to the contrary, the commissioner of insurance shall promulgate regulations requiring any carrier, as defined in section 1 of chapter 176O of the General Laws, and their contractors to comply with and implement the federal Mental Health Parity and Addiction Equity Act, section 511 of Public Law 110-343, and applicable state mental health parity laws, including section 22 of chapter 32A of the General Laws, section 47B of chapter 175 of the General Laws, section 8A of chapter 176A of the General Laws, section 4A of chapter 176B of the General Laws and sections 4, 4B and 4M of chapter 176G of the General Laws. The commissioner of insurance shall promulgate said regulations not later than January 1, 2013. The regulations shall be implemented as part of

any provider contract and any carrier's health benefit plans delivered, issued, entered into, renewed, or amended on or after July 31, 2013.

Starting on July 1, 2014, the commissioner of insurance shall require all carriers and their contractors, to submit an annual report to the division of insurance and to the attorney general, which shall be a public record, certifying and outlining how their health benefit plans comply with the federal Mental Health Parity and Addiction Equity Act, applicable state mental health parity laws, including said section 22 of said chapter 32A, said section 47B of chapter 175, said section 8A of chapter 176A, said section 4A of chapter 176B and said sections 4, 4B and 4M of chapter 176G, and this section. The division of insurance may, at the request of the attorney general, or in its own discretion, hold a public hearing relative to a carrier's or contractor's annual report.

SECTION 255. Notwithstanding the provisions of any general or special law or regulation to the contrary, the provisions of section 16T of chapter 6A of the General Laws shall not apply to the review of an application for a determination of need that is filed with the department of public health under any applicable provision of said chapter 6A on or before December 31, 2013.

SECTION 256. Notwithstanding any general or special law to the contrary, the health planning council shall submit a state health plan to the governor and the general court, as required by section 16T of chapter 6A of the General Laws, on or before January 1, 2014.

SECTION 257. Notwithstanding subsection (d) of section 25C of chapter 111, health care providers that receive written notice from the department of public health, prior to December 31,

2013, that they do not need a determination of need review for a project shall be exempt from the requirement to file a determination of need under said subsection for such project.

SECTION 258. Notwithstanding any general or special law to the contrary, the board of registration in medicine, established under section 10 of chapter 13 of the General Laws, may promulgate regulations relative to the education and training of physicians in the early disclosure of adverse events including, but not limited to, continuing education requirements. Nothing in this section shall affect the total hours of continuing education required by the board, including the number of hours required relative to risk management.

SECTION 259. Notwithstanding any general or special law to the contrary, the department of public health, in consultation with the division of insurance, shall examine and study best practices and successful models of private sector wellness and health management programs in order to create a model wellness guide for payers, employers and consumers. The department shall also issue a report that identifies those elements of said programs that should be promoted in support of the state's efforts to meet the health care cost growth benchmark established under section 9 of chapter 6D of the General Laws.

The model guide shall provide the following information: (i) the importance of healthy lifestyles, disease prevention, care management and health promotion programs; (ii) financial and other incentives for brokers, payers and consumers to encourage health and wellness program offerings for consumers and to expand options for individuals who do not have access to these programs through their workplace; (iii) benefit designs that tie financial consequences to health care choices; (iv) use of technology to provide wellness information and services; (v) the benefits of participating in tobacco cessation programs and weight loss programs; (vi) the

importance of chronic disease management, and complying with prescribed drug and follow up treatment regimens to reduce hospitalization for high-risk populations; (vii) a description of the discounts available to employees under the Affordable Care Act; and (viii) identifying qualitative and quantitative program measures to place real value on program results and track program effectiveness.

In developing the report and model guide, the commissioner shall consult with health care stakeholders, including but not limited to: employers, including representatives of employers with more than 50 employees and representatives of employers with less than 50 employees; providers and provider organizations; health carriers; public payers; researchers; community organizations; consumers; and other governmental entities. The report, along with any recommendations, shall be submitted to the clerks of the house of representatives and the senate, the joint committee on health care financing, the house and senate committees on ways and means and the secretary of health and human services by January 1, 2013. The recommendations shall assist in the development of strategies and programs supported by the Prevention and Wellness Trust Fund established under section 2G of chapter 111 of the General Laws.

SECTION 260. Notwithstanding any general or special law to the contrary, the board of registration in nursing, established under section 13 of chapter 13 of the General Laws, may promulgate regulations relative to the education and training of advanced practice nurses authorized to practice under section 80B of chapter 112 of the General Laws, in the early disclosure of adverse events including, but not limited to, continuing education requirements. Nothing in this section shall affect the total hours of continuing education required by the board.

SECTION 261. Notwithstanding and special or general law to the contrary, the office of Medicaid shall develop alternative payment methodologies including, but not limited to, bundled payments, global payments, shared savings and other innovative methods of paying for health care services. The office of Medicaid shall take actions necessary to amend its managed care organization and primary care clinician contracts as necessary to include such contracts in the innovation project. In developing the innovation project that employs alternative payment methodologies, the office of Medicaid shall consider payment and quality metric alignment with existing accountable care demonstrations implemented by the Centers for Medicare and Medicaid Services. The office of Medicaid shall consult with stakeholders including, but not limited to, the health care quality and cost commission, hospitals or hospital associations, carriers or carrier associations, consumer groups, physician or physician associations, and other health care providers, including safety net providers and high Medicaid and low-income public payer hospitals on developing alternative payment methodologies under this section. The office of Medicaid shall ensure that alternative payment methodologies: (i) support the state's efforts to meet the health care cost growth benchmark and to improve health, care delivery and cost-effectiveness; (ii) include incentives for high quality, coordinated care, including wellness services, primary care services and behavioral health services; (iii) include a risk adjustment element based on health status; (iv) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors; (v) preserve the use of intergovernmental transfer financing mechanisms by governmental acute public hospitals consistent with the Medical Assistance Trust Fund provisions in effect as of fiscal year 2012; and (vi) recognize the unique circumstances and reimbursement requirements of high Medicaid disproportionate share hospitals and other safety net providers with concentrated care in

government programs. The office of Medicaid may also consider methodologies to account for the following costs: (1) medical education; (2) stand-by services and emergency services, including, but not limited to, trauma units and burn units; ; (3) services provided by disproportionate share hospitals or other providers serving underserved populations, including but not limited to, groups which suffer adverse health outcomes based on race, sex, ethnicity, disability, housing type, income level, primary language or educational attainment; (4) services provided to children; (5) research; (6) care coordination and community based services provided by allied health professionals, including, but not limited to, community health workers, legal advocates, medical interpreters, clinical prevention specialists, human services workers, social workers and licensed alcohol and drug counselors; (7) the greater integration of behavioral, substance use disorder and mental health; (8) the use and the continued advancement of new medical technologies, treatments, diagnostics or pharmacology products that offer substantial clinical improvements and represent a higher cost than the use of current therapies; (9) culturally and linguistically appropriate services; (10) interpreter services; (11) dedicated care management responsibilities and administrative responsibilities in alternative payment methodologies; and (12) costs associated with the services of a comprehensive cancer center, as defined in section 8A of chapter 118E of the General Laws.

In making the transition to alternative payment methodologies, the office of Medicaid shall achieve the following benchmarks, to the maximum extent feasible:

(i) Not later than July 1, 2013, the office of Medicaid shall pay for health care utilizing alternative payment methodologies for no fewer than 25 per cent of its enrollees that are not also covered by other health insurance coverage, including Medicare and employer-sponsored or privately purchased insurance.

(ii) Not later than July 1, 2014, the office of Medicaid shall pay for health care utilizing alternative payment methodologies for no fewer than 50 per cent of its enrollees that are not also covered by other health insurance coverage, including Medicare and employer-sponsored or privately purchased insurance.

(iii) Not later than July 1, 2015, the office of Medicaid shall pay for health care utilizing alternative payment methodologies for no fewer than 80 per cent or the maximum percentage feasible of its enrollees that are not also covered by other health insurance coverage, including Medicare and employer-sponsored or privately purchased insurance.

SECTION 262. Notwithstanding any special or general law to the contrary, in fiscal year 2014, the secretary of health and human services shall provide an increase of 2 per cent to rates paid by the office of medicaid to acute care hospitals, non-acute care hospitals and to providers of primary care services that accept alternative payment methodologies from the office of Medicaid or any Medicaid managed care organization. The amount of the rate increase shall not exceed $20,000,000 in the aggregate, and shall be in addition to any annual rate calculations, including updates for inflation, case-mix adjustments, base year updates and any other improvements to the rate methodology. The office of Medicaid shall only apply this rate increase to those hospitals and providers that have demonstrated to the satisfaction of MassHealth a significant transition to the use of alternative payment methodologies. The rate increase to qualifying hospitals and providers shall apply to all health care services provided to medical assistance recipients including outpatient, inpatient and behavioral health services, including, but not limited to, those under primary care clinician and mental health and substance abuse plans or through a Medicaid managed care organization. The office of Medicaid may establish by regulation what constitutes a significant use of alternative payment methodologies by a provider.

The office of Medicaid shall not offset the rate increase by reducing Medicaid base rates to acute hospitals or providers of primary care. The office of Medicaid shall, to the greatest extent possible, seek federal financial participation to offset the cost of implementing this section

SECTION 263. Notwithstanding any general or special law to the contrary, the health policy commission shall investigate and review methods of, and make recommendations relative to, increasing the use and adoption of flexible spending accounts, health reimbursement arrangements, health savings accounts and similar tax-favored health plans and developing and implementing incentives to increase the utilization of these types of plans. The health policy commission shall examine the feasibility of such accounts and plans for public payers and commercial insurers and the feasibility of a pilot program. The health policy commission shall submit a report of its findings and recommendations to the clerks of the house of representatives and the senate, the house and senate committees on ways and means and the joint committee on health care financing not later than April 1, 2013.

SECTION 264. Notwithstanding any general or special law to the contrary, the department of revenue shall conduct a study to investigate the implementation of a pilot program to increase the adoption of health reimbursement arrangements, health savings accounts, flexible spending accounts and similar plans in the marketplace, including state employees and persons receiving subsidized health care. The study commission shall be chaired by the commissioner of revenue and shall include: 1 member representing consumers appointed by the governor; 1 member who shall be appointed by the president of the senate; 1 member who shall be appointed by the minority leader of the senate; 1 member who shall be appointed by the speaker of the house of representatives; 1 member who shall be appointed by the minority leader of the house of representatives; the executive director of the group insurance commission, or a designee; 1

member who shall represent the Massachusetts Bankers Association; 1 member who shall represent the Massachusetts Association of Health Underwriters; 1 member who shall represent the Massachusetts Association of Health Plans; 1 member who shall represent Blue Cross and Blue Shield of Massachusetts; and 1 member who shall represent the Associated Industries of Massachusetts. The commission shall file a report with recommendations, and any legislation that may be necessary for implementation, with the clerks of the house of representatives and senate, the senate and house committees on ways and means and the joint committee on health care financing not later than April 1, 2013.

The scope of the study shall include, but not be limited to, identifying: (i) the barriers to full implementation of flexible spending accounts, health reimbursement accounts, health savings accounts and other tax-favored health plans; (ii) providing greater consumer choice; and (iii) incentives to increase utilization of flexible spending accounts, health reimbursement accounts, health savings accounts and other tax-favored health plans.

SECTION 265. Notwithstanding any general or special law or rule or regulation to the contrary, the office of Medicaid shall promulgate regulations requiring any Medicaid health plan and managed care organization and their health plans and any behavioral health management firm and third party administrator under contract with a Medicaid managed care organization to comply with and implement the federal Mental Health Parity and Addiction Equity Act, section 511 of Public Law 110-343, and applicable state mental health parity laws, including section 22 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and sections 4, 4B and 4M of chapter 176G of the General Laws. The office of Medicaid shall promulgate such regulations not later than January 1, 2013. The regulations shall be

implemented as part of any provider contracts and any carrier's health benefit plans delivered, issued, entered into, renewed or amended on or after July 13, 2013.

Starting on July 1, 2014, the office of Medicaid shall submit an annual report to the house and senate chairs of the joint committee on health care financing, the house and senate chairs of the joint committee on mental health and substance abuse, the clerk of the senate, the clerk of the house of representatives and the attorney general certifying and outlining how the health benefit plans under the office of Medicaid, and their contractors, comply with the federal Mental Health Parity and Addiction Equity Act, applicable state mental health parity laws, including said section 22 of said chapter 32A, said section 47B of said chapter 175, said section 8A of said chapter 176A, said section 4A of said chapter 176B, and said sections 4, 4B and 4M of said chapter 176G, and this section. The office of Medicaid may hold a hearing relative to a health benefit plan's or contractor's compliance with this section.

SECTION 266. The office of Medicaid shall, within 6 months of the passage of this act, take any and all necessary actions to ensure that social security numbers are required on all medical benefits request forms to the extent permitted by federal law and that Social Security numbers are provided by all applicants who possess them. Further, the executive office of health and human services shall, within 6 months of the effective date of this act, ensure that the identity, age, residence and eligibility of all applicants are verified before payments, other than emergency bad debt payments, are made by the Health Safety Net Trust Fund;

If for any reason the office of Medicaid or the executive office of health and human services determines that it is or will be unable to accomplish the foregoing within 6 months of the effective date of this act, said respective office shall submit a detailed report of the reasons

for such inability to the clerks of the house of representatives and the senate within 6 months of the effective date of this act.

SECTION 267. (a) Notwithstanding any general or special law to the contrary, the executive office of health and human services shall pursue all reasonable efforts to automatically renew eligible children and families into the MassHealth program, through the adoption of the express-lane eligibility option created under section 203 of the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3, as it pertains to renewals, and through the extension of that approach to all children and their eligible parents enrolled in medical assistance under chapter 118E of the General Laws. Specifically, the executive office shall seek federal authority under the section 1115 of the Social Security Act demonstration process or the state plan to automatically re-enroll all children and the eligible parents who are eligible for other state or federal assistance programs whose eligibility requirements are within the requirements for the applicable MassHealth program.

(b) The executive office of health and human services shall provide families with renewal forms for all programs administered under said chapter 118E in which the fields have been pre-populated with the most current information known to the executive office. This subsection shall be effective not later than January 1, 2014.

(c) There shall be a study committee to investigate the feasibility and cost of continuous MassHealth eligibility for children under the age of 19 to ensure that the same health care plans are offered through MassHealth and Commonwealth Care so that persons transitioning between different payers do not have to switch health plans. The committee shall consist of the following members: the director of the office of Medicaid, or a designee, who shall serve as chair; the

secretary of health and human services, or a designee; the secretary of administration and finance, or a designee; the house chair of the joint committee on health care financing, or a designee; the senate chair of the joint committee on health care financing, or a designee; and a representative of health care consumers, to be appointed by the governor. The committee shall formulate relevant Medicaid state plan amendments, cost projections and information technology specifications necessary to implement continuous eligibility for children not later than June 30, 2014.

(d) Notwithstanding any general or special law to the contrary, the executive office of health and human services shall conduct an investigation of all federal and state assistance programs to determine which programs share eligibility requirements with MassHealth and which could feasibly share data with the MassHealth program for purposes of renewing eligible children and their eligible parents in MassHealth through the express-lane eligibility option created under said Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3. The executive office shall submit a report on the results of such investigation by filing the same with the clerks of the house of representatives and the senate who shall forward the report to the house and senate committees on ways and means, the joint committee on health care financing and the joint committee on children and families and persons with disabilities not later than April 1, 2013.".

SECTION 268. Notwithstanding any general or special law to the contrary, to the extent that the office of Medicaid, the group insurance commission, the commonwealth health insurance connector authority and any other state funded insurance program determine that provider organizations organized as ACOs offer opportunities for cost-effective and high quality care, such state funded insurance programs shall prioritize provider organizations which have

been certified by the board of the commission as ACOs, and designated as Model ACOs, for the delivery of publicly funded health services, provided that such ACOs, to the extent possible, assure the continuity of patient care.

SECTION 269. Notwithstanding any special of general law to the contrary, for fiscal years 2013 through 2017 the center for health information and analysis and the health policy commission shall enter into an interagency agreement to transfer funds as necessary to support the transfer of functions from the center for health information and analysis to the health policy commission to supplement any funding needed in addition to those funds provided by the Healthcare Payment Reform Fund established in section 100 of chapter 194 of the acts of 2011. The executive director of the center for health information and analysis shall notify the comptroller of the amount to be transferred.

SECTION 270. There shall be a special commission to review public payer reimbursement rates and payment systems for health care services and the impact of such rates and payment systems on health care providers and on health insurance premiums in the commonwealth. The commission shall consist of 13 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the director of the office of Medicaid; 1 of whom shall be the executive director of the center for health information and analysis; 1 of whom shall be appointed by the Massachusetts Hospital Association; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed by the Home Care Alliance of Massachusetts; 1 of whom shall be appointed by the Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the Massachusetts Association for Behavioral Healthcare; 1 of whom shall represent a

disproportionate share hospital; 1 of whom shall represent non-physician health care providers; and 2 of whom shall be appointed by the governor, 1 of whom shall be represent managed care organizations contracting with MassHealth and 1 of whom shall be an expert in medical payment methodologies from a foundation or academic institution.

The commission shall examine whether public payer rates and rate methodologies provide fair compensation for health care services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care. The commission's analysis shall include, but not be limited to, an examination of MassHealth rates and rate methodologies; current and projected federal financing, including Medicare rates; cost-shifting and the interplay between public payer reimbursement rates and health insurance premiums; possible funding sources for increased MassHealth rates including, but not limited to, utilizing increased federal Medicaid assistance percentage funds received under the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, and section 1201 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152; and the degree to which public payer rates reflect the actual cost of care.

To conduct its review and analysis, the commission may contract with an outside organization with expertise in the analysis of health care financing. The center for health information and analysis and the office of Medicaid shall provide the outside organization, to the extent possible, with any relevant data necessary for the evaluation; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than April 1, 2013.

SECTION 271. Notwithstanding any law or rule the contrary, for fiscal year 2014, in establishing Medicaid reimbursement rates for inpatient services provided by chronic disease rehabilitation hospitals located in the commonwealth that serve solely children and adolescents, the department of health and human services shall apply a multiplier of 1.5 times the hospital's inpatient per diem rate in fiscal year 2012. For fiscal year 2015 and fiscal year 2016, such rates of reimbursement shall not be lower than the rates in effect for the prior fiscal year.

SECTION 272. Notwithstanding any general or special law to the contrary, the department of public health, in consultation with the Betsy Lehman center for patient safety and medical error reduction, established under section 16E of chapter 6A of the General Laws, shall create an independent task force consisting of no more than 11 members from a broad distribution of diverse perspectives to study and reduce the practice of defensive medicine and medical overutilization in the commonwealth, including but not limited to the overuse of imaging and screening technologies. The task force shall issue a report on the financial and non-financial impacts of defensive medicine and the impact of overutilization on patient safety. The task force shall file a report of its study, including its recommendations and drafts of any legislation, if necessary, by filing the same with the clerks of the senate and house of representatives who shall forward a copy of the report to the joint committee on public health 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

prescription pharmaceutical provider; and (iv) the feasibility of creating a program to provide all citizens access to prescription pharmaceuticals at prices negotiated by the commonwealth.

(c) The commission shall report the results of its findings, together with any recommendations for legislation, programs and funding by filing the same with the clerks of the house of representatives and the senate who shall forward copies of the report to the house and senate committees on ways and means and the joint committee on health care financing not later than 12 months after the passage of this act.

SECTION 274. There shall be a special task force to study and investigate issues related to the accuracy of medical diagnosis in the commonwealth. The task force shall investigate and report on: (i) the extent to which diagnoses in the commonwealth are accurate and reliable, including the extent to which different diagnoses and inaccurate diagnoses arise from the biological differences between the sexes; (ii) the underlying systematic causes of inaccurate diagnoses; (iii) an estimation of the financial cost to the state, insurers and employers of inaccurate diagnoses; (iv) the negative impact on patients caused by inaccurate diagnoses; and (v) recommendations to reduce or eliminate the impact of inaccurate diagnoses.

The Massachusetts diagnostic accuracy task force shall be comprised of 9 members: 1 of whom shall be the secretary of health and human services, who shall chair the task force; 1 of whom shall be the commissioner of public health or a designee; 1 of whom shall be the chair of the board of registration in medicine or a designee; 1 of whom shall be the chair of the board of registration in nursing or a designee; and 5 members chosen by the governor, 1 of whom shall be a provider with experience in the area of diagnostic accuracy,1 of whom shall be a representative of a Massachusetts health plan, 1 of whom shall be an employer with experience in

implementing programs to address diagnostic inaccuracy, 1 whom shall represent an organization based in the commonwealth with experience creating and supporting the implementation of programs on diagnostic accuracy and value-based benefit design, and 1 of whom shall be a non-physician health care provider.

SECTION 275. There shall be a special task force to examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral, substance use disorder and mental health reimbursement systems. The task force shall consist of 19 members: 1 whom shall be the commissioner of mental health, who shall serve as the chair; 1 of whom shall be a representative of the Massachusetts Psychiatric Society; 1 of whom shall be a representative of the Massachusetts Psychological Association; 1 of whom shall be a representative of the National Association of Social Workers-Massachusetts Chapter; 1 of whom shall be a representative of the Massachusetts Mental Health Counselors Association; 1 of whom shall be a representative of the Nurses United for Responsible Services; 1 of whom shall be a representative of the Massachusetts Association for Registered Nurses; 1 of whom shall be a representative of the Massachusetts Association of Behavioral Health Systems; 1 of whom shall be a representative of the Association for Behavioral Healthcare ; 1 of whom shall be a representative of the Mental Health Legal Advisors Committee; 1 of whom shall be a representative of the National Alliance for the Mentally Ill; 1 of whom shall be a representative of the Children's Mental Health Campaign; 1 of whom shall be a representative of the Home Care Alliance of Massachusetts; 1 of whom shall be a representative of the National Empowerment Center; 1 of whom shall be a representative of the Massachusetts Organization for Addiction Recovery; 1 of whom shall be a representative of the Recovery Homes Collaborative; 1 of whom shall be a representative of the Massachusetts

Hospital Association; and 3 members chosen by the Governor: 1 of whom shall be a provider with experience serving difficult to reach populations; 1 of whom shall be a provider with experience in severing dually diagnosed patients; and 1 of whom shall be a school nurse. In its examination, the task force shall review: (i) the most effective and appropriate approach to including behavioral, substance use and mental health disorder services in the array of services provided by provider organizations, including risk-bearing providers and patient-centered medical homes, including transition planning and maintaining continuity of care; (ii) how current prevailing reimbursement methods and covered behavioral, substance use and mental health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral, substance use and mental health outcomes; (iii) the extent to which and how payment for behavioral health services should be included under alternative payment methodologies, including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols; (iv) how best to educate all providers to recognize behavioral, substance use and mental health conditions and make appropriate decisions regarding referral to behavioral health services; (v) how best to educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness; and (vi) the unique privacy factors required for the integration of behavioral, substance use and mental health information into interoperable electronic health records. The task force shall submit its report, findings, and recommendations, along with any proposed legislation and regulatory changes, to the health policy commission, the clerks of the senate and house of representatives, and the house and senate chairs of the joint committee on mental health and substance abuse, and the house and senate chairs of the joint committee on 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

health conditions; (ii) the extent to which the program reduced health care costs or the growth in health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the reduction; (iv) the extent to which workplace-based wellness or health management programs were expanded, and whether those programs improved employee health, productivity and recidivism; (v) if employee health and productivity was improved or employee recidivism was reduced, the estimated statewide financial benefit to employers; (vi) recommendations for whether the program should be discontinued, amended or expanded, as well as a timetable for implementation of the recommendations; and (vii) recommendations for whether the funding mechanism for the Prevention and Wellness Trust Fund should be extended beyond 2016, or whether an alternative funding mechanism should be established

(c) To conduct its evaluation, the commission shall contract with an outside organization with expertise in the analysis of health care financing. In conducting its evaluation, the outside organization shall, to the extent possible, obtain and use actual health plan data from the all-payer claims database as administered by the center for health information and analysis; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

(d) The commission shall report the results of its investigation and study and its recommendation, if any, together with drafts of legislation necessary to carry out such recommendation to the house and senate committees on ways and means, the joint committee on public health and shall be posted on the department's website not later than June 30, 2015.

SECTION 277. There shall be a special commission to examine the economic, social and educational value of graduate medical education in the commonwealth and to recommend a fair

and sustainable model for the future funding of graduate medical education in the commonwealth.

The commission shall consist of 13 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be the secretary of labor and workforce development or a designee; 1 of whom shall be the commissioner of public health or a designee; and 9 whom shall be appointed by the secretary of health and human services, 1 of whom shall be a representative of the Massachusetts Hospital Association; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the Massachusetts League of Community Health Centers; 4 of whom shall represent the commonwealth's medical schools; 1 of whom shall be a representative of the Conference of Boston Teaching Hospitals; and 1 of whom shall be a resident in training at a Massachusetts hospital.

The commission shall investigate and report on the following issues:

(1) the role of residents and medical faculty in the provision of health care in the commonwealth and throughout the United States;

(2) the relationship of graduate medical education to the state's physician workforce and emerging models of delivery of care;

(3) the current availability and adequacy of all sources of revenue to support graduate medical education and potential additional or alternate sources of funding for graduate medical education. Such review shall include the availability of federal graduate medical education funding to different types of sites where training takes place; and

(4) approaches taken by other states to fund graduate medical education through, including, but not limited to: (a) Medicaid programs, (b) the establishment of medical education trust funds and (c) efforts to link payments to state policy goals, including:

(i) increasing the number of high demand specialties or fellowships;

(ii) enhancing retention of physicians practicing in the commonwealth;

(iii) promoting practice in medically underserved areas of the state and reducing disparities in health care;

(iv) increasing the primary care workforce;

(v) increasing the behavioral health care workforce; and

(vi) increasing racial and ethnic diversity within the physician workforce.

The commission shall file a report of its findings and recommendations, together with drafts of legislation, if any, necessary to carry out its recommendations by filing the report with the clerks of the house of representatives and the senate who shall forward a copy of the report to the house and senate committees on ways and means and the joint committee on health care financing not later than April 1, 2013.

SECTION 278. Notwithstanding any general or special law to the contrary, beginning on or before July 1, 2014, the group insurance commission, MassHealth and any other state funded insurance program shall, to the maximum extent feasible, implement alternative payment methodologies, as defined in section 1 of chapter 12C of the General Laws.

SECTION 279. There shall be a special commission to review variation in prices among providers. The commission shall consist of 18 members: 1 of whom shall be the executive director of the center of health information and analysis or a designee, who shall serve as co-chair; 1 of whom shall be the executive director of the health policy commission, who shall serve as co-chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be the executive director of the group insurance commission or a designee; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the attorney general or a designee; 6 of whom shall be appointed by the governor, 1 of whom shall be a health economist, 1 of whom shall represent a high Medicaid and low-income public payer disproportionate share hospital, 1 of whom shall represent a hospital with 200 beds or less, 1 of whom shall represent a pharmaceutical manufacturer who shall be headquartered in the commonwealth, 1 of whom shall be a representative of an employer with less than 50 employees, and 1 of whom shall be a representative of an employer with more than 50 employees; 1 of whom shall be a representative of the Massachusetts Council of Community Hospitals; 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a representative of a medical device manufacturer who shall be headquartered in the commonwealth; and 1 of whom shall be a representative of the Conference of Boston Teaching Hospitals. In making appointments, the governor shall, to the maximum extent feasible, ensure that the commission represents a broad distribution of diverse perspectives.

The commission shall conduct a rigorous, evidence based analysis to identify the acceptable and unacceptable factors contributing to price variation in physician, hospitals, diagnostic testing and ancillary services. The analysis shall include, but not be limited to, an examination of the following factors: quality, medical education, stand-by service capacity, emergency service capacity, special services provided by disproportionate share hospitals and other providers serving underserved or unique populations, market share of individual providers and affiliated providers, provider size, advertising, location, research, costs, care coordination, community-based services provided by allied health professionals and use of and continued advancement of medical technology and pharmacology. The analysis shall also include a comparison of price variation between providers in the commonwealth and providers in other states and a review of the feasibility of requiring insurers to separately contract with all provider locations for a multi-location provider, rather than contracting only with the individual provider locations and a review of contracting practices that require payers to pay the same or similar prices to all provider locations for a multi-location health care provider where geographic differences in the provider's site do not support charging the same or similar prices.

After identifying the factors contributing to price variation, the commission shall recommend steps to reduce provider price variation and shall recommend the maximum reasonable adjustment to a commercial insurer's median rate for individual or groupings of services for each acceptable factor. To conduct its review and analysis, the commission may contract with an outside organization with expertise in the analysis of health care financing and provider payment methodologies. The center for health information and analysis shall provide the commission and any contracted outside organization, to the extent possible, relevant data

necessary for the evaluation; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the study with the health policy commission and the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than January 1, 2014.

SECTION 280. (a) Notwithstanding any general or special law to the contrary, the group insurance commission, the commonwealth health insurance connector authority, the office of Medicaid and any other state funded insurance program shall implement, to the maximum extent possible, alternative payment methodologies. The alternative payment methodologies shall be developed in consultation with all affected publically funded health plans, including, but not limited to, the Medicaid managed care organizations; provided, however, that any such agency or program shall be subject to any other implementation requirements provided for by law.

(b) The executive office of health and human services shall seek a federal waiver of statutory provisions necessary to permit Medicare to participate in such alternative payment methodologies. Upon obtaining federal approval for Medicare participation, such participation shall be commenced and continued and the executive office shall seek extensions or additional approvals, as necessary. If federal approval cannot be obtained, or is revoked, then the requirements of this chapter, shall be conformed to federal standards for accountable care, shared savings, bundled payments, or alternative payment arrangements, to the greatest extent 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;

(4) the functions of the health care quality and cost council related to the consumer health information website, as the transferor agency, to the center for health information analysis, as the transferee agency;

(4) the functions of the department of public health related to the statewide advisory committee on the standard quality measure set, as the transferor agency, to the center for health information analysis, as the transferee agency;

(5) the functions of the department of public health related to the office of patient protection, as the transferor agency, to the health policy commission, as the transferee agency;

(6) the functions of the Betsy Lehman center for patient safety and medical error reduction, as the transferor agency, to the center for health information analysis, as the transferee agency;

(b) To the extent that employees of the transferor agency, including those who were appointed immediately before the effective date of this act and who hold permanent appointment in positions classified under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are transferred to the respective transferee agency, such transfers shall be effected without interruption of service within the meaning of said section 9A of said chapter 30, without impairment of seniority, retirement or other rights of the employee, and without reduction in compensation or salary grade, notwithstanding any change in title or duties resulting from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and benefits, and without change in union representation or certified collective bargaining unit as certified by the state division of labor relations or in local union representation or affiliation. Any

collective bargaining agreement in effect immediately before the transfer date shall continue in effect and the terms and conditions of employment therein shall continue as if the employees had not been so transferred. The reorganization shall not impair the civil service status of any such reassigned employee who immediately before the effective date of this act either holds a permanent appointment in a position classified under said chapter 31 or has tenure in a position by reason of said section 9A of said chapter 30. Notwithstanding any other general or special law to the contrary, all such employees shall continue to retain their right to collectively bargain under chapter 150E of the General Laws and shall be considered employees for the purposes of said chapter 150E. Nothing in this section shall be construed to confer upon any employee any right not held immediately before the date of said transfer, or to prohibit any reduction of salary grade, transfer, reassignment, suspension, discharge, layoff or abolition of position not prohibited before such date.

(c) All petitions, requests, investigations and other proceedings appropriately and duly brought before the transferor agency or duly begun by the transferor agency and pending before it before the effective date of this act, shall continue unabated and remain in force, but shall be assumed and completed by the transferee agency.

(d) All orders, rules and regulations duly made and all approvals duly granted by the transferor agency, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency.

(e) All books, papers, records, documents, equipment, buildings, facilities, cash and other property, both personal and real, including all such property held in trust, which immediately

before the effective date of this act are in the custody of the transferor agency shall be transferred to the transferee agency.

(f) All duly existing contracts, leases and obligations of the transferor agency shall continue in effect but shall be assumed by the transferee agency. No existing right or remedy of any character shall be lost, impaired or affected by this act.

(g) The comptroller shall be authorized to take any actions necessary to support the transfers outlined in this section. No existing right or remedy of any character shall be lost, impaired or affected by this act.

SECTION 281A. The division of insurance shall develop uniform prior authorization forms for different health care services and benefits under subsections (c) and (d) of section 24 of chapter 176O of the General Laws not later than October 1, 2013.

SECTION 281B. The division of insurance shall promulgate regulations to implement section 26 of chapter 176O of the General Laws not later than July 1, 2014.

SECTION 283. Section 13 of chapter 6D of the General Laws shall take effect on January 1, 2013.

SECTION 284. Section 6 of said chapter 6D shall take effect on July 1, 2016.

SECTION 285. Section 228 of chapter 111 of the General Laws shall take effect on January 1, 2014.

SECTION 286. Section 7 of chapter 118I of the General Laws shall take effect on January 1, 2017.

SECTION 287. Section 6 of said chapter 118I shall take effect on January 1, 2017.

SECTION 288. Section 108M of chapter 175 of the General Laws shall take effect on October 1, 2013.

SECTION 289. Section 37 of chapter 176A of the General Laws shall take effect on October 1, 2013.

SECTION 290. Section 24 of chapter 176B of the General Laws shall take effect on October 1, 2013.

SECTION 291. Section 32 of chapter 176G of the General Laws shall take effect on October 1, 2013.

SECTION 292. Section 17 of chapter 176J of the General Laws shall take effect on October 1, 2013.

SECTION 293. Section 24 of chapter 176O of the General Laws shall take effect on October 1, 2013.

SECTION 294. Section 25 of said chapter 176O shall take effect on January 1, 2014.

SECTION 295. Section 36 shall take effect on October 1, 2013.

SECTION 296. Section 37 shall take effect on October 1, 2014.

SECTION 297. Section 41 and section 56 shall take effect on January 1, 2013.

SECTION 298. Section 41A and 56A shall take effect on December 31, 2017.

SECTION 299. Section 108 shall take effect as of January 1, 2015.

SECTION 301. Sections 141 and 142 shall take effect on July 1, 2013.

SECTION 302. Section 175 shall take effect on April 1, 2014.

SECTION 303. Section 176 shall take effect on April 1, 2015.

SECTION 304. Section 199 shall take effect on October 1, 2015.

SECTION 305. Section 200 shall take effect on October 1, 2013.

SECTION 306. Section 271 is hereby repealed.

SECTION 307. Section 306 shall take effect on June 30, 2016.

SECTION 308. Section 177 shall take effect on April 1, 2013.

HOUSE DOCKET, NO. 3625 FILED ON: 5/3/2013

HOUSE . . . . . No. 3452

The Commonwealth of Massachusetts

EXECUTIVE DEPARTMENT
STATE HOUSE · BOSTON 02133
(617) 725-4000

DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

May 3, 2013

To the Honorable Senate and House of Representatives,

I am filing for your consideration a bill entitled, "An Act Implementing the Affordable Care Act and Providing Further Access to Affordable Health Care." This legislation will allow Massachusetts to realize the full benefits of the Affordable Care Act, including expanded federal funding to support coverage for low and middle-income families and federal insurance reforms that will secure additional protections for Massachusetts residents.

The legislative package includes a number of changes that will allow Massachusetts to align with the Affordable Care Act, such as:

- Implementing a transition period in the merged individual/small group market to allow Massachusetts to conform to federal rating factor requirements;

- Implementing the ACA requirement that health insurance rates for individuals be filed on a calendar year basis, but allowing small group rates to be filed on a quarterly basis until 2016;

- Aligning the Commonwealth's definition of who is eligible to purchase non-group insurance with the federal definition;

- Conforming the state's insurance laws to align with ACA requirements;

- Aligning MassHealth and Connector eligibility definitions with ACA definitions; and

- Allowing for data to be shared with EOHHS and the Connector so that eligibility for MassHealth or subsidized coverage through the Exchange can be verified in real-time through the new on-line integrated eligibility system.

Enacting these provisions builds on the progress we have already made to improve health care coverage in our state. I urge your prompt and favorable consideration of this legislation.

Respectfully submitted

Deval L. Patrick,
Governor

HOUSE . . . . . No. 3452

Message from His Excellency the Governor recommending legislation relative to implementing the Affordable Care Act and providing further access to affordable health care. Ways and Means.

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

An Act implementing the Affordable Care Act and providing further access to affordable health care.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to which is to expand forthwith access to health care for Massachusetts residents, therefore, it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health.

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

SECTION 1. Section 16 of chapter 6A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by adding the following paragraph:-

Notwithstanding any general or special law to the contrary, the executive office of health and human services may request from any agency, department, division, commission, board, authority, and other public or quasi-public entity in the commonwealth, and such agencies and entities shall provide, any information, including personal data as defined in chapter 66A and data in the wage reporting system administered by the department of revenue pursuant to chapter 62E, that the executive office of health and human services determines, in its judgment, as being reasonably necessary to make available, determine eligibility for, enroll individuals in, and otherwise administer various public benefit programs authorized under chapter 118E or other programs that the executive office of health and human services may administer in accord with the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time, or that the executive office of health and human services determines, in its judgment, as being reasonably necessary to develop and administer a single integrated eligibility system, in conjunction with the commonwealth health insurance connector authority, through which the executive office of health and human services may make available, determine eligibility for, enroll individuals in, and otherwise administer such public benefit programs, and through which the commonwealth health insurance connector authority will execute its statutory responsibilities

under chapter 176Q, provided the provision of such information to the executive office of health and human services for such purposes is consistent with federal law. Further, notwithstanding any general or special law to the contrary, the executive office of health and human services is authorized to provide to the commonwealth health insurance connector authority any information the executive office of health and human services obtains pursuant to section 23 of chapter 118E as is reasonably necessary for the commonwealth health insurance connector authority to perform its duties pursuant to chapter 176Q.

SECTION 2. Section 1 of chapter 6D, as inserted by section 15 of chapter 224 of the acts of 2012, is hereby amended by striking out the definition "Public health care payer" and inserting in place thereof the following definition:-

"Public health care payer", the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid 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, 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.

SECTION 3. Subsection (d) of section 8 of said chapter 6D, as inserted by section 15 of chapter 224 of the acts of 2012, is hereby amended by striking out, in clause (vii), the words "or under the commonwealth care health insurance program".

SECTION 4. Section 1 of chapter 12C, as inserted by section 19 of chapter 224 of the acts of 2012, is hereby amended by striking out the definition "Public health care payer" and inserting in place thereof the following definition:-

"Public health care payer", the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid 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, including prepaid health plans subject to the provisions of 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.

SECTION 5. Chapter 26 of the General Laws is hereby amended by inserting after section 8K the following section:-

Section 8L. In regard to any carrier licensed under chapters 175, 176A, 176B, 176E, 176F, and 176G, the commissioner of insurance may implement and enforce applicable provisions of the federal Patient Protection and Affordable Care Act, Public Law 111–148, as amended from time to time and of the Women's Health and Cancer Rights Act, Public Law: 105-277, as well as any rules, regulations, or guidance applicable thereto, as amended from time to time, including but not limited to the amendments made by title X of the federal Patient

Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152 and the Indian Health Care Improvement Reauthorization and Extension Act of 2009, as enacted in amended form by section 10221 of the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended from time to time.

SECTION 6. Section 4N of chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 23, the words “or the commonwealth care health insurance program”.

SECTION 7. Section 217 of chapter 111 of the General Laws is hereby repealed.

SECTION 8. Section 51 of chapter 112 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 60 and 61, the words “or the commonwealth care health insurance program”.

SECTION 9. Section 8 of chapter 118E of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out the definition “Person” and inserting in place thereof the following definition:-

“Person”, any individual who resides in the commonwealth, or any individual residing outside the commonwealth who is deemed to be a resident of the commonwealth under Title XIX, Title XXI or other state or federal programs established or administered pursuant to this chapter.

SECTION 10. Said section 8 of said chapter 118E, as so appearing, is hereby further amended by striking out the definition “Reside” and inserting in place thereof the following definition:-

“Reside” to occupy an established place of abode with no present intention of definite and early removal, but not necessarily with the intention of remaining permanently, but in no event shall the word “reside” be construed more restrictively or less restrictively than as defined by the Secretary under Title XIX, Title XXI or other state or federal programs established or administered pursuant to this chapter.

SECTION 11. Section 9 of said chapter 118E, as so appearing, is hereby amended by inserting after the word “A,” in line 11, the following words:- , and such other persons as may be required under Title XIX and regulations adopted thereunder

SECTION 12. Said section 9 of said chapter 118E, as so appearing, is hereby further amended by inserting after the third sentence the following sentence:-

In addition to the foregoing, medical assistance under this chapter may be made available to such other persons as may be permitted under Title XIX or Title XXI and regulations adopted thereunder.

SECTION 13. Said section 9 of said chapter 118E, as so appearing, is hereby further amended by adding the following paragraph:-

The secretary of the executive office may establish a program to provide subsidies to assist eligible individuals in purchasing health insurance, provided that such subsidies shall only be paid on behalf of an eligible individual who is enrolled in a health plan that has been procured by the MassHealth program and shall be made under a sliding-scale premium contribution payment schedule for enrollees, as determined by MassHealth. Eligible individuals are residents of the Commonwealth up to 300 per cent of poverty who are not eligible for Federal advanced premium tax credits, who are ineligible for any other benefits provided pursuant to this chapter, and who are permanently residing in the United States under color of law, provided that the individual has not moved into the commonwealth for the sole purpose of securing health insurance under this chapter and provided further that confinement of an individual in a nursing home, hospital or other medical institution in the commonwealth shall not, in and of itself, suffice to qualify an individual as a resident.

SECTION 14. Section 9A of said chapter 118E, as so appearing, is hereby amended by inserting after the word “1315a,” in line 9, the following words:- or any other federal waiver or demonstration authority

SECTION 15. Subsection (1) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out the definition “Expansion beneficiaries”.

SECTION 16. Said subsection (1) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out the definition “Medical benefits” and inserting in place thereof the following definition:-

“Medical benefits” health care services including managed care programs, provided to beneficiaries pursuant to the terms and conditions of a demonstration project and regulations promulgated by the division and including, but not limited to, assistance with premiums and costs sharing and medical insurance purchased for beneficiaries pursuant to section eighteen or benefits authorized by 42 USC 1396e.

SECTION 17. Said subsection (1) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out the definition “Traditional beneficiaries.”

SECTION 18. Subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out subdivision (b) and inserting in place thereof the following subdivision:-

(b) infants to age one and pregnant women whose financial eligibility as determined by the division does not exceed 200 per cent of the federal poverty level, and children and

adolescents aged one to 20 years, inclusive, whose financial eligibility as determined by the division does not exceed 150 per cent of the federal poverty level;

SECTION 19. Said subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out subdivision (d) and inserting in place thereof the following subdivision:-

(d) persons aged 21 to 64, inclusive, whose financial eligibility as determined by the division does not exceed 133 per cent of the federal poverty level, provided however, that such persons shall meet such other eligibility criteria that the division and the secretary may establish;

SECTION 20. Said subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by adding the following subdivision:-

(j) premium assistance for employer sponsored health insurance for adults up to 300 per cent of the poverty level who are uninsured at the time of application, are not eligible for any other program under this chapter and cannot purchase a qualified health plan through the health connector because they have access to employer sponsored minimum essential coverage as defined in section 1401 of the federal Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time.

SECTION 21. Said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out, in line 130, the word “the” where it appears before the word “demonstration”, and inserting in place thereof the word:- a

SECTION 22. Subsection (6) of said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out the first two sentences.

SECTION 23. Said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 157, 164, 174, 179, 211, and 212 the word “the” and inserting in place thereof, in each instance, the following word:- a

SECTION 24. Said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out, in line 182, the words “for expansion beneficiaries”.

SECTION 25. Section 9B of said chapter 118E of the General Laws is hereby repealed.

SECTION 26. Section 10 of said chapter 118E of the General Laws, as so appearing, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-

The division may, to the extent permitted by Title XIX or other federal authority, provide medical assistance to pregnant women who are presumptively eligible for the period of time prescribed by federal law or other federal authority. The division shall promulgate regulations to implement this section, which shall require health care providers to notify such pregnant women

of the need to file an application for Medicaid and which shall set standards to be used by providers in determining presumptive eligibility.

SECTION 27. Section 12 of said chapter 118E, as so appearing, is hereby amended by inserting after the words “Title XIX,” in line 21, the words:- and Title XXI

SECTION 28. Section 16D of said chapter 118E, as so appearing, is hereby amended by striking out, in line 40, the words “MassHealth Essential” and inserting in place thereof the following words:- MassHealth Family Assistance.

SECTION 29. Section 27 of said chapter 118E, as so appearing, is hereby amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) Periodically in accordance with federal law.

SECTION 30. Said section 27 of said chapter 118E, as so as appearing, is hereby further amended by inserting after the word “shall,” in line 12, the following words:- to the extent required by federal law

SECTION 31. Section 64 of chapter 118E, as inserted by section 131 of chapter 224 of the acts of 2012, is hereby amended by striking out, in the definition “Payments subject to surcharge”, the words “(2) enrollees in the commonwealth care health insurance program”.

SECTION 32. Paragraph (ii) of subsection (a) of section 66 of said chapter 118E, as inserted by section 131 of chapter 224 of the acts of 2012, is hereby amended by striking out the words “this chapter and the commonwealth care health insurance program under chapter 118H”.

SECTION 33. Subsection (b) of said section 66 of chapter 118E, as inserted by section 131 of chapter 224 of the acts of 2012, is hereby further amended by striking out the words “and the commonwealth care health insurance programs” and inserting in place thereof the following word:- program

SECTION 34. Subsection (a) of section 69 of said chapter 118E, as inserted by section 131 of chapter 224 of the acts of 2012, is hereby amended by striking out, in paragraph (3), the words “or for the commonwealth care health insurance program, established under chapter 118H,”.

SECTION 35. Chapter 118H of the General Laws is hereby repealed.

SECTION 36. Subsection (c) of section 46 of chapter 151A, as appearing in the 2010 Official Edition, is hereby amended by striking out paragraph (7) and inserting in place thereof the following paragraph:-

(7) to the commonwealth health insurance connector authority, information under an interagency agreement for the administration and enforcement of chapter 176Q and for the

administration of the fair share employer contribution requirement under section 188 of chapter 149.

SECTION 37. Said subsection (c) of said section 46 of said chapter 151A, as so appearing, is hereby amended by striking out Paragraph (8).

SECTION 38. Subsection 2. of section 108 of chapter 175 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in paragraph (a), subparagraph (3) and inserting in place thereof the following subparagraph:-

(3) It purports to insure only 1 person, except that a policy, excluding contracts which provide stand-alone dental services, shall insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be considered the policyholder, 2 or more eligible members of that family, including the policyholder, spouse, dependent children and other dependent persons, children during pendency of adoption procedures under chapter 210, children under 26 years of age, and children who are mentally or physically incapable of earning their own living, if due proof of the incapacity is received by the insurer within 31 days of the date upon which the coverage would otherwise be terminated; and

SECTION 39. Section 110 of said chapter 175, as so appearing, is hereby amended by striking out subsection (P) and inserting in place thereof the following subsection:-

(P) A blanket or general policy of insurance described in subdivision (A), (C) or (D), except policies or certificates which provide stand-alone dental services or coverage to Medicare or other governmental programs which shall be delivered, issued or renewed in the commonwealth, shall provide, as benefits to all group members having a place of employment in the commonwealth, coverage to dependent persons under 26 years of age.

SECTION 40. Chapter 176A of the General Laws is hereby amended by striking out section 8BB, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

Section 8BB Any subscription certificate under an individual or group nonprofit hospital service agreement, except certificates which provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, that is delivered, issued or renewed in the commonwealth, shall provide, as benefits to all individuals or to all group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

SECTION 41. Chapter 176B of the General Laws is hereby amended by striking out section 4BB, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

Section 4BB. Any subscription certificate under an individual or group medical service agreement, except certificates that provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, that is delivered or issued or renewed in the commonwealth, shall provide, as benefits to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

SECTION 42. Chapter 176G of the General Laws is hereby amended by striking out section 4T, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

Section 4T. A health maintenance contract, except certificates which provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, shall provide, as benefits to all individuals or to group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

SECTION 43. Section 1 of chapter 176J of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out the definition “Eligible dependent” and inserting in place thereof the following definition:-

“Eligible dependent,” the spouse or child of an eligible person, subject to the applicable terms of the health benefit plan covering such employee. The child of an eligible individual or eligible employee shall be considered an eligible dependent until the end of the child’s 26th year of age.

SECTION 44. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition “Eligible individual” and inserting in place thereof the following definition:-

“Eligible individual”, an individual who is a resident of the commonwealth.

SECTION 45. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by inserting after the definition of “Financial impairment”, the following definition”:-

“Grandfathered health plan”, any group health plan or health insurance coverage to which 42 USC 18011 applies.

SECTION 46. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition “Pre-existing conditions provision”.

SECTION 47. Said section 1 of said chapter 176J, as so appearing, is hereby further amended by striking out the definition “Waiting period”.

SECTION 48. Chapter 176J is amended by striking out Section 3, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

Section 3. (a)(1) For every health benefit plan issued or renewed to eligible individuals and eligible small groups, including a certificate issued to an eligible individual or eligible small group that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, a carrier shall develop a group base premium rate that is the same for eligible individuals and eligible small groups. In developing these merged market group base premium rates, carriers are to do as follows:

(i) With respect to the group base premium rate developed for eligible individuals and eligible small groups, a carrier must consider all enrollees in those health plans, other than grandfathered health plans, offered by such carrier to be members of a merged individual and small group risk pool;

(ii) In calculating the premium to be charged to each eligible individual or eligible small group, a carrier shall develop a base premium and use only those rate adjustment factors identified in this section, inclusive, for all insured health benefit plans offered to eligible individuals and eligible small groups, respectively, with all other rating adjustments being prohibited;

(iii) Carriers may offer any rate basis types, but rate basis types that are offered to any eligible individual or eligible small group shall be offered to every eligible individual or eligible small group for all coverage issued or renewed. If an eligible small group does not meet a carrier's minimum or participation contribution requirements, the carrier may separately rate each employee as an eligible individual, as set forth in paragraph (i), above;

(iv) Carriers shall apply the same rating factors when calculating premiums for eligible individuals as are used when calculating premiums for eligible small groups; and

(v) Notwithstanding the provisions of this section, all carriers offering any coverage to any eligible individual or eligible small group is required to make that coverage available to every eligible individual and eligible small group.

(2) The commissioner shall annually file with the federal department of health and human services to establish a standard age rate adjustment factor table so that the ratio of the highest factor for adults over age 20 compared to the lowest factor for adults over age 20 shall not exceed a ratio of two-to-one. A carrier that elects to apply standard age rate adjustment factors must apply them based upon the covered person's age when the coverage period begins.

(3) The commissioner shall annually file with the federal department of health and human services to establish no more than 7 distinct regions of the state for the purposes of area rate adjustments. A carrier may establish an area rate adjustment for each distinct region, the value of which shall range from eight-tenths to one and two-tenths. If a carrier chooses to apply area rate adjustments, every eligible individual and eligible small group within each area shall be subject to the applicable area rate adjustment.

(4) A carrier shall establish a rate basis type adjustment factor for eligible individuals and eligible small groups which shall vary the rate only on the basis of whether the health benefit plan covers an individual or family. For purposes of this section, the total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium.

(5) The commissioner shall annually file with the federal department of health and human services to establish a standard tobacco use factor; a carrier may apply a tobacco use rate factor in a manner permitted under state and federal law that applies to both eligible small groups and eligible individuals provided that the carrier uses a certification of tobacco use process that has been approved by the commissioner to determine that eligible individuals and their eligible dependents or eligible small group employees and their eligible dependents have not used tobacco products within the past year.

(6) A carrier may establish a benefit level rate adjustment for all eligible individuals and eligible small groups that shall be expressed as a number. The number shall represent the relative actuarial value of the benefit level, including the health care delivery network, of the health benefit plan issued to that eligible individual or eligible small group as compared to the actuarial value of other health benefit plans within that class of business. If a carrier chooses to establish benefit level rate adjustments, every eligible individual and every eligible small group shall be subject to the applicable benefit level rate adjustment.

(7) A carrier may not apply any rate factor adjustment to the group base premium rate, other than those set forth herein.

(b)(1) A carrier that as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under chapter 176G, shall be required annually to file a plan with the connector for its consideration, which could attain the connector seal of approval; provided however, the plan shall be filed no later than October 1 of any calendar year.

(2) A carrier that as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its authority under chapter 175, 176A or 176B, shall be required annually to file a plan with the connector for its consideration, which could attain the connector seal of approval; provided however, the plan shall be filed no later than October 1 of any calendar year.

(c) For the purposes of this section, neither an eligible individual or eligible employee, nor an eligible dependent, shall be considered to be enrolled in a health benefit plan issued pursuant to its authority under chapter 175, 176A or 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under chapter 176G.

(d) The commissioner may conduct an examination with respect to the derivation of group base premium rates used to develop individual group premiums in order to identify whether any expenses inappropriately increase the cost in relation to the risks of the merged individual and small group health insurance market.

SECTION 49. Subsection (a) of section 4 of said chapter 176J, as so appearing, is hereby amended by striking out clause (2), and inserting in place thereof the following clause:-

(2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible individuals, as defined in section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 300gg-41(b), into a health plan if those individuals request coverage within 63 days of termination of any prior creditable coverage. A carrier shall also enroll eligible individuals, as permitted under the federal Patient Protection and Affordable Care Act, and any rules, regulations and guidances applicable thereto, as amended from time to time. A carrier shall enable any such eligible individual to renew coverage if that coverage is available to other eligible individuals. Coverage shall become effective in accordance with the federal Patient Protection and Affordable Care Act, and any rules, regulations and guidances applicable thereto, as amended from time to time, subject to reasonable verification of eligibility, and shall be effective through December 31 of that same year. Carriers shall notify any such eligible individuals that:

(i) coverage shall be in effect only through December 31 of the year of enrollment;

(ii) if any such eligible individual is in a health plan with a plan-year deductible or out-of- pocket maximum, then an explanation of how that deductible or out-of- pocket maximum and premiums will be impacted for the period between the plan effective date and December 31 of the enrollment year; and

(iii) the next open enrollment period during which any such eligible individual shall have the opportunity to enroll in a health plan that will begin on January 1 of the following calendar year.

A carrier shall not impose a pre-existing condition exclusion or waiting period of any duration on a health plan.

SECTION 50. Said chapter 176J is hereby amended by striking out section 5, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

Section 5. No policy shall exclude an eligible individual, eligible employee or eligible dependent on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition.

SECTION 51. Section 6 of said chapter 176J, as so appearing, is hereby amended by striking out subsection (c) and inserting in place thereof the following subsection:-

(c) Notwithstanding any general or special law to the contrary, carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, shall file small group product base rates and any changes to small group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. Rates of reimbursement or rating factors included in the rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

SECTION 52. Section 9 of said chapter 176J, as so appearing, is hereby amended by striking out, in lines 64 and 65, the words “which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary,”.

SECTION 53. Section 12 of said chapter 176J, as amended by section 179 of chapter 224 of the acts of 2012, is amended by striking out subsection (h) and inserting in place thereof the following subsection:-

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

SECTION 54. Section 13 of said chapter 176J, as so appearing, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

(b) Health benefit plans offered by carriers to group purchasing cooperatives shall: (i) include all state-mandated benefits; (ii) apply open enrollment periods for individuals in the same manner as the carrier applies them for individuals outside the group purchasing cooperative, provided, however that small business group purchasing cooperatives shall establish rules and open enrollment periods for qualified association members to enter or exit group purchasing cooperatives; (iii) apply continuation of coverage provisions in the same manner as

the carrier applies those provisions to small group products offered outside the group purchasing cooperative; (iv) apply managed care practices in the same manner as the carrier applies those practices to small group products offered outside the group purchasing cooperative; and (v) apply rating rules, including rating bands, rating factors and the value of rating factors, in the same manner as the carrier applies those rules to small group products offered outside the group purchasing cooperative.

SECTION 55. Chapter 176N of the General Laws is hereby amended by striking out section 2, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

Section 2. No health plan shall:

(a) exclude any eligible insured on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage, or medical condition of such person.

(b) exclude late enrollees from coverage for more than twelve months from the date of the application for coverage of any late enrollee.

(c) In any circumstance in which more extensive coverage than that provided by clauses (a) and (b) is required by any other provision of the General Laws or any law of the United States, the health benefit plan shall satisfy such other provision insofar as it requires more extensive coverage.

SECTION 56. Section 1 of chapter 176O of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out the definition “Grievance” and inserting in place thereof the following definition:-

“Grievance”, any oral or written complaint submitted to the carrier which has been initiated by an insured, or on behalf of an insured with the consent of the insured, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations, in accordance with the requirements of this chapter.

SECTION 57. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by striking out the definition “Office of patient protection” and inserting in place thereof the following definition:-

“Office of patient protection”, the office in the health policy commission established by section 16 of chapter 6D, responsible for the administration and enforcement of sections 13, 14, 15 and 16.

SECTION 58. Said section 1 of said chapter 176O, as so appearing, is hereby further amended by striking out the definition “adverse determination” and inserting in place thereof the following definition:-

“Adverse determination” based upon a review of information provided by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness, including a determination that a requested or recommended health care service or treatment is experimental or investigational.

SECTION 59. Section 2 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 22 and 23, the words “division of health care finance and policy” and inserting in place thereof the following words:- center for health information and analysis

SECTION 60. Said section 2 of said chapter 176O, as so appearing is hereby amended by striking out, in lines 28 and 29, the words “department of public health established by section 217 of chapter 111” and inserting in place thereof the following words:- health policy commission established by section 16 of chapter 6D

SECTION 61. Section 6 of said chapter 176O, as so appearing, is hereby amended by striking out, in line 54, the words “section 217 of chapter 111” and inserting in place thereof the following words:- section 16 of chapter 6D

SECTION 62. Said section 6 of said chapter 176O, as so appearing, is hereby further amended by striking out, in line 56, the words “in the department of public health” and inserting in place thereof the following words:- or, where applicable, the designated state consumer assistance program

SECTION 63. Section 7 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 23 and 24, the words “the department of public health under section 25P of chapter 111” and inserting in place thereof the following words:- center for health information analysis

SECTION 64. Said section 7 of said chapter 176O, as so appearing, is hereby further amended by striking out, in lines 45 and 55, the words “department of public health” and inserting in place thereof, in each instance, the following words:- health policy commission

SECTION 65. Section 13 of said chapter 176O, as so appearing, is hereby amended by striking out, in line 2, the word “provides” and inserting in place thereof the following words:- is compliant with the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended from time to time as with as well as any rules, regulations, or guidance applicable thereto, and such formal internal grievance process shall provide

SECTION 66. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is hereby amended by adding after clause (iii), the following clause:-

(iv) a resolution of a claim involving urgently needed services within 72 hours.

SECTION 67. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is hereby amended by adding the following sentence:-

In the event that an insured claims that a carrier failed to properly act on a grievance that is an adverse determination within the time limits required by this section, such claim is immediately eligible for external review, notwithstanding the requirement in section 14 that the insured must complete the internal review process.

SECTION 68. Said section 13 of said chapter 176O, as so appearing, is hereby further amended by adding the following subsection:-

(d) An insured may request an expedited review of a grievance and at the same time may request an expedited external review of the grievance pursuant to section 14.

SECTION 69. Section 14 of said chapter 176O, as so appearing, is hereby amended by striking out subsection (a), and inserting in place thereof the following subsection:-

(a) An insured who remains aggrieved by an adverse determination and has exhausted all remedies available from the formal internal grievance process required pursuant to section 13, may seek further review of the grievance by a review panel established by the office of patient protection pursuant to paragraph (5) of subsection (a) of section 16 of chapter 6D. The insured shall pay the first $25 of the cost of the review to said office, which may waive the fee in cases of extreme financial hardship and which shall refund the fee to the insured if the adverse determination is reversed in its entirety. No insured shall be required to pay more than $75 per plan year, regardless of the number of external review requests submitted. The carrier shall be responsible for the remainder of the cost of the review pursuant to regulations promulgated by the executive director of the health policy commission in consultation with the commissioner of insurance. The office of patient protection shall contract with at least three unrelated and objective review agencies through a bidding process, and refer grievances to one of the review agencies on a random selection basis. The review agencies must be accredited by a national accrediting organization and shall develop review panels appropriate for the given grievance, which shall include qualified clinical decision-makers experienced in the determination of medical necessity, utilization management protocols and grievance resolution, and shall not have any financial relationship with the carrier making the initial determination. The standard for review of a grievance by such a panel shall be the determination of whether the requested treatment or service is medically necessary, as defined herein, and a covered benefit under the policy or contract. The panel shall consider, but not be limited to considering: (i) written documents submitted by the insured, (ii) additional information from the involved parties or

outside sources that the review panel deems necessary or relevant, and (iii) information obtained from any informal meeting held by the panel with the parties. The panel shall send final written disposition of the grievance, and the reasons therefore, to the insured and the carrier within 45 days of receipt of the request for review. Notwithstanding the requirements of this section, an insured may request an external review of an adverse determination without exhausting the carrier's internal appeals process if the insured is seeking an expedited review or if the carrier failed to meet the time limits specified in section 13.

SECTION 70. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is hereby amended by adding the following two sentences:-

There shall be a process for the expedited review of grievances. The external review panel shall send final written disposition of the grievance, and the reasons therefore, to the insured and the carrier within 72 hours of receipt of the request for review.

SECTION 71. Said section 14 of said chapter 176O, as so appearing, is hereby further amended by inserting after the word "binding", in line 40, the following words:- on the insured and on the carrier

SECTION 72. Section 17 of said chapter 176O as so appearing, is hereby amended by striking out, in line 2, the words "commissioner of public health" and inserting in place thereof the following words:- health policy commission

SECTION 73. Section 20 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 26 and 27, the words "office of patient protection, established by section 217 of chapter 111," and inserting in place thereof the following words:- designated state consumer assistance program

SECTION 74. Section 1 of chapter 176Q of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out the definition "Commonwealth care health insurance program".

SECTION 75. Said section 1 of said chapter 176Q, as so appearing, is hereby further amended by striking out the definition "Commonwealth care health insurance program enrollees".

SECTION 76. Said section 1 of said chapter 176Q, as so appearing, is hereby further amended by striking out the definition "Eligible individual" and inserting in place thereof the following definition:-

"Eligible individual", an individual who is a resident of the commonwealth and who is qualified to purchase coverage through the connector pursuant to 42 U.S.C. § 18032(f).

SECTION 77. Said Section 1 of said chapter 176Q, as so appearing, is hereby further amended by inserting after the definition “Eligible small group” the following 2 definitions:-

“Federal advanced premium tax credits”, a payment made pursuant to 26 U.S.C. § 36B on behalf of an eligible individual or eligible child to reduce the value of a health benefit plan premium.

“Federal point-of-service cost-sharing reductions”, a payment made pursuant to 26 U.S.C. § 36B on behalf of an eligible individual or eligible child to reduce point-of-service cost-sharing expenses which shall include, but not be limited to, copayments, coinsurance and deductibles.

SECTION 78. Said Section 1 of said chapter 176Q is hereby further amended by striking out the word “offset” in the definition “Point-of-service cost-sharing subsidy”, as inserted by section 38 of chapter 118 of the Acts of 2012, and inserting in place thereof the following word:- reduce.

SECTION 79. Said Section 1 of said chapter 176Q is hereby further amended by striking out the definition “Premium assistance payment”, as inserted by section 38 of chapter 118 of the Acts of 2012, and inserting in place thereof the following definition:-

“Premium assistance payment”, a payment made to a carrier or an individual by the connector to reduce the value of a health benefit plan premium paid by the individual.

SECTION 80. Said section 1 of said chapter 176Q, as appearing in the 2010 Official Edition, is hereby further amended by striking out the definition of “Rating factor” and inserting in place thereof the following definition:-

“Rating factor”, characteristics including, but not limited to, age, rate basis type and geography.

SECTION 81. Section 3 of said chapter 176Q, as so appearing, is hereby amended by striking out, in line 5, the words “groups and commonwealth care health insurance plan enrollees”, and inserting in place thereof the following words:- and eligible small groups

SECTION 82. Said section 3 of said chapter 176Q, as so appearing, is hereby further amended by striking out, in line 15 and lines 30 and 31, the words “groups and commonwealth care health insurance program enrollees” and inserting in place thereof, in each instance, the following words:- and eligible small groups

SECTION 83. Said section 3 of said chapter 176Q, as so appearing, is hereby further amended by striking out, in lines 23 and 24, the words “the commonwealth care health insurance program, established by chapter 118H” and inserting in place thereof the following words:- premium assistance payments or cost-sharing subsidies

SECTION 84. Said section 3 of said chapter 176Q, as so appearing, is hereby further amended by striking out, in line 33, the word “all”.

SECTION 85. Said section 3 of said chapter 176Q, as so appearing, is hereby further amended by inserting after the word “payments”, in line 38, the following words:- and point-of-service cost-sharing subsidies and, if applicable, federal advanced premium tax credits and federal point-of-service cost-sharing reductions

SECTION 86. Subsection (a) of said section 3 of said chapter 176Q, as so appearing, is hereby further amended by striking out paragraph (13) and inserting in place thereof the following paragraph:-

(13) develop a standard application form for eligible individuals and eligible small groups seeking to purchase health insurance through the connector; and

SECTION 87. Subsection (b) of said section 3 of said chapter 176Q, as amended by section 43 of chapter 118 of the Acts of 2012, is hereby amended by inserting after the word “or” the following words:- point-of-service.

SECTION 88. Subsection (m) of said section 3 of said chapter 176Q, as amended by section 132 of chapter 139 of the Acts of 2012, is hereby amended by striking out the words “111M, 118E, 118G 118H” and inserting in place thereof the following words:- 6D, 12C, 15A, 111M, 118E

SECTION 89. Said section 3 of said chapter 176Q is hereby amended by striking out subsection (o).

SECTION 90. Subsection (u) of said section 3 of said chapter 176Q, as inserted by section 7 of chapter 96 of the Acts of 2012, is hereby amended by striking out paragraph (2) and inserting in place thereof the following paragraph:- (2) the determination of eligibility of individuals for shopping, receiving federal advanced premium tax credits and qualifying for federal point-of-service cost-sharing reductions through the Exchange, as provided by federal law; and

SECTION 91. Subsection (a) of section 4 of said chapter 176Q, as amended by section 45 of chapter 118 of the Acts of 2012, is hereby amended by striking out the words “, including all health benefit plans offered through the commonwealth care health insurance program”.

SECTION 92. Section 7 of chapter 176Q is hereby repealed.

SECTION 93. Subsection (a) of section 12 of said chapter 176Q, as amended by section 49 of chapter 118 of the Acts of 2012, is hereby amended by striking out the last sentence.

SECTION 94. Said chapter 176Q is hereby further amended by striking out section 8, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

Section 8. (a) The connector shall enter into interagency agreements with the department of revenue, the executive office of health and human services, the department of public health, the executive office of labor and workforce development, the registry of motor vehicles, the department of correction, the center for health information and analysis and any such other state agencies, departments, divisions, commissions, authorities or political subdivisions, and the foregoing agencies, departments, divisions, commissions, authorities and political subdivisions are hereby authorized to furnish pursuant to such agreements, information, including personal data as defined in chapter 66A, that is necessary for the connector to perform its duties under this chapter, including the determination of an individual's eligibility for federal advanced premium tax credits and federal point-of-service cost-sharing reductions and adjudication of appeals arising from such determinations. Such written agreements shall include provisions permitting the department of revenue to furnish the data available under the wage reporting system established under section 3 of chapter 62E. The department of revenue is hereby authorized to furnish the connector with information on the cases of persons so identified, including, but not limited to, name, social security number and other data to ensure positive identification, name and identification number of employer, and amount of wages received and gross income from all sources. The connector shall not utilize any of the data received from the department of revenue for any solicitations or advertising.

(b) The connector is hereby authorized to receive and use any information provided pursuant to section 23 of chapter 118E as necessary for the connector to perform the duties under this chapter, including the determination of an individual's eligibility for federal advanced premium tax credits and federal point-of-service cost-sharing reductions and adjudication of appeals arising from such determinations.

SECTION 95. Section 15 of said chapter 176Q, as so appearing, is hereby amended by striking out, in lines 14 to 16, inclusive, the words ", the operation and administration of the commonwealth care health insurance program described in chapter 118H".

SECTION 96. Section 1 of chapter 176T, as inserted by section 216 of chapter 224 of the acts of 2012, is hereby amended by striking out the definition "Public health care payer" and inserting in place thereof the following definition:-

"Public health care payer", the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid 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, including prepaid health plans subject to the provisions of 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.

SECTION 97. Section 66 of chapter 288 of the Acts of 2010, as amended by section 234 of chapter 224 of the Acts of 2012, is hereby repealed.

SECTION 98. Section 226 of chapter 224 of the Acts of 2012 is hereby repealed.

SECTION 99. Section 227 of chapter 224 of the Acts of 2012 is hereby repealed.

SECTION 100. Section 246 of chapter 224 of the Acts of 2012 is hereby repealed.

SECTION 101. Section 253 of chapter 224 of the Acts of 2012 is hereby amended by striking out the words ", the commonwealth care health insurance program established under chapter 118H of the General Laws, any carrier or other entity which contracts with the commonwealth care health insurance program to pay for or arrange for the purchase of health care services".

SECTION 102. Notwithstanding any provisions of chapter 176J of the Massachusetts General Laws to the contrary, and only for the period from January 1, 2014 through December 31, 2015, carriers will be permitted to develop the group base premium for eligible small employers so that the group base premium will vary by enrollment or renewal month and shall be filed as part of a rate filing for each calendar quarter.

In addition, notwithstanding any provisions of chapter 176J to the contrary, and only for the period from January 1, 2014 through December 31, 2015, in calculating the premium to be charged to each eligible small group or eligible individual, carriers will be permitted to utilize and apply a portion of the following rate adjustment factors, based on the factors a carrier has in place as of July 1, 2013, in addition to those permitted under chapter 176J: (1) an industry rate adjustment factor; (2) a participation rate adjustment factor; (3) a group size rate adjustment factor; (4) an intermediary rate adjustment factor; and (5) a group purchasing cooperative rate adjustment.

The commissioner of insurance shall have the authority to issue regulations to implement this section, including, but not limited to, regulations setting forth the manner in which carriers may utilize and apply the additional rate adjustment factors set forth in this section during the period from January 1, 2014 through December 31, 2015.

SECTION 103. Sections 1, 5, and 94 shall take effect 30 days after passage of this act.

SECTION 104. Sections 2 to 4, inclusive, 6 to 50, inclusive, 52 to 93, inclusive, and 95 to 101, inclusive, shall take effect January 1, 2014.

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Acts 2013

CHAPTER 35 AN ACT IMPLEMENTING THE AFFORDABLE CARE ACT AND PROVIDING FURTHER ACCESS TO AFFORDABLE HEALTH CARE.

Whereas, The deferred operation of this act would tend to defeat its purpose, which is to expand forthwith access to health care for Massachusetts residents, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health.

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

SECTION 1. Section 16 of chapter 6A of the General Laws, as most recently amended by section 5 of chapter 224 of the acts of 2012, is hereby further amended by adding the following paragraph:- Notwithstanding any general or special law to the contrary, the executive office of health and human services may request from any agency, department, division, commission, board, authority, or other public or quasi-public entity in the commonwealth, and they shall provide, any information, including personal data, as defined in section 1 of chapter 66A and data in the wage reporting system administered by the department of revenue pursuant to chapter 62E, that the executive office of health and human services determines to be necessary to make available, determine eligibility for, enroll individuals in and otherwise administer various public benefit programs authorized pursuant to chapter 118E or other programs that the executive office of health and human services may administer in accord with the Patient Protection and Affordable Care Act, Public Law 111-148, as amended from time to time, or that the executive office of health and human services determines, in its judgment, as being reasonably necessary to develop and administer a single integrated eligibility system, in conjunction with the commonwealth health insurance connector authority, through which the executive office of health and human services may make available, determine eligibility for, enroll individuals in and otherwise administer such public benefit programs, and through which the commonwealth health insurance connector authority will execute its statutory responsibilities pursuant to chapter 176Q; provided, that the provision of such information to the executive office of health and human services for such purposes is consistent with federal law. Further, notwithstanding any general or special law to the contrary, the executive office of health and human services is authorized to provide to the commonwealth health insurance connector authority any information the executive office of health and human services obtains pursuant to section 23 of chapter 118E as necessary for the commonwealth health insurance connector authority to perform its duties pursuant to chapter 176Q.

SECTION 2. Section 1 of chapter 6D, as appearing in section 15 of said chapter 224, is hereby amended by striking out the definition of “Public health care payer” and inserting in place thereof the following definition:-
“Public health care payer”, the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid 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 of the Social Security Act, including prepaid health plans subject to section 28 of chapter 47 of the acts of 1997; the group insurance commission established pursuant to chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

SECTION 3. Clause (vii) of subsection (d) of section 8 of said chapter 6D, as so appearing, is hereby amended by striking out the words “or under the commonwealth care health insurance program”.

SECTION 4. Section 1 of chapter 12C, as appearing in section 19 of said chapter 224, is hereby amended by striking out the definition of “Public health care payer” and inserting in place thereof the following definition:-
“Public health care payer”, the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid 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 of the Social Security Act, including prepaid health plans subject to section 28 of chapter 47 of the acts of 1997; the group insurance commission established pursuant to chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

SECTION 4A. Section 18 of chapter 15A of the General Laws, as amended by section 20 of said chapter 224, is hereby further amended by striking out the first paragraph and inserting in place thereof the following paragraph:-
Every full-time and part-time student enrolled in a public or independent institution of higher learning located in the commonwealth shall participate in a qualifying student health insurance program. For the purposes of this section, “part-time student” shall mean a student participating in at least 75 per cent of the full-time curriculum. Such an institution may allow students to waive participation in its student health insurance program or any part thereof; provided, however, that such an institution shall require students waiving participation to certify in writing prior to any academic year in which the student will not participate in the institution's plan that such student is a participant in a health insurance program providing comparable coverage; and provided further, that such institution shall allow students to waive participation in its student health insurance program if the student is currently enrolled in MassHealth, the student continues to meet all relevant MassHealth eligibility criteria under state and federal law and: (i) the student has been enrolled in MassHealth for at least 1 year prior to becoming eligible for the institution’s student health insurance program or (ii) the

student has been enrolled in MassHealth for at least 6 months and the student provides documentation, as required by the commonwealth health insurance connector in consultation with MassHealth, that participation in the qualifying student health insurance program would be financially prohibitive.

SECTION 5. Chapter 26 of the General Laws is hereby amended by inserting after section 8K the following section:-
Section 8L. In regard to any carrier licensed pursuant to chapters 175, 176A, 176B, 176E, 176F and 176G, the commissioner of insurance may implement and enforce: (i) the Patient Protection and Affordable Care Act, Public Law 111–148, as well as any rules, regulations or guidance applicable thereto, as amended from time to time; and (ii) the Women's Health and Cancer Rights Act of 1998, Public Law 105-277, as well as any rules, regulations or guidance applicable thereto, as amended from time to time, including, but not limited to, the amendments made by: Title X of said Patient Protection and Affordable Care Act; the Health Care and Education Reconciliation Act of 2010, Public Law 111–152; and the Indian Health Care Improvement Reauthorization and Extension Act of 2009, as enacted in amended form by section 10221 said federal Patient Protection and Affordable Care Act.

SECTION 6. Section 4N of chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 23, the words "or the commonwealth care health insurance program".

SECTION 7. Section 217 of said chapter 111 is hereby repealed.

SECTION 8. Section 51 of chapter 112 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 60 and 61, the words "or the commonwealth care health insurance program".

SECTION 9. Section 8 of chapter 118E of the General Laws, as so appearing, is hereby amended by striking out the definition of "Person" and inserting in place thereof the following definition:-
"Person", any individual who resides in the commonwealth, or any individual residing outside the commonwealth who is deemed to be a resident of the commonwealth under Title XIX, Title XXI or other state or federal programs established or administered pursuant to this chapter.

SECTION 10. Said section 8 of said chapter 118E, as so appearing, is hereby further amended by striking out the definition of "Reside" and inserting in place thereof the following definition:-
"Reside", to occupy an established place of abode with no present intention of definite and early removal, but not necessarily with the intention of remaining permanently, but in no event shall the word "reside" be construed more restrictively or less restrictively than as defined by the Secretary

under Title XIX, Title XXI or other state or federal programs established or administered pursuant to this chapter.

SECTION 11. Section 9 of said chapter 118E is hereby amended by inserting after the word “A”, in line 11, as so appearing, the following words:- , and such other persons as may be required under Title XIX and regulations adopted thereunder.

SECTION 12. The second paragraph of said section 9 of said chapter 118E is hereby further amended by inserting after the second sentence, as so appearing, the following sentence:- In addition to the foregoing, medical assistance under this chapter may be made available to such other persons as may be permitted under Title XIX or Title XXI and regulations adopted thereunder.

SECTION 13. Said section 9 of said chapter 118E, as amended by section 24 of chapter 118 of the acts of 2012, is hereby further amended by adding the following paragraph:-
The secretary of the executive office may establish a program to provide subsidies to assist eligible individuals in purchasing health insurance, provided that such subsidies shall only be paid on behalf of an eligible individual who is enrolled in a health plan that has been procured by the MassHealth program and shall be made under a sliding-scale premium contribution payment schedule for enrollees, as determined by MassHealth. Eligible individuals are residents of the commonwealth whose income is 300 per cent or less of the federal poverty level as calculated pursuant to the regulations of the executive office, who are not eligible for federal advanced premium tax credits, who are ineligible for any other benefits provided pursuant to this chapter, and who are permanently residing in the United States under color of law; provided, that the individual has not moved into the commonwealth for the sole purpose of securing health insurance under this chapter; and provided further, that confinement of an individual in a nursing home, hospital or other medical institution in the commonwealth shall not, in and of itself, suffice to qualify an individual as a resident.

SECTION 14. Section 9A of said chapter 118E, as appearing in the 2010 Official Edition, is hereby amended by inserting after the figure “1315a”, in line 9, the following words:- or any other federal waiver or demonstration authority.

SECTION 15. Subsection (1) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out the definition of “Expansion beneficiaries”.

SECTION 16. Said subsection (1) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out the definition of “Medical benefits” and inserting in place thereof the following definition:-
“Medical benefits”, health care services including managed care programs, provided to beneficiaries pursuant to the terms and conditions of a demonstration project and regulations promulgated by the

division and including, but not limited to, assistance with premiums and costs sharing and medical insurance purchased for beneficiaries pursuant to section 18 or benefits authorized by 42 U.S.C. section 1396e.

SECTION 17. Said subsection (1) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out the definition of “Traditional beneficiaries”.

SECTION 18. Subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out clause (b) and inserting in place thereof the following clause:-
(b) infants to age 1 and pregnant women whose financial eligibility, as determined by the division, does not exceed 200 per cent of the federal poverty level and children and adolescents aged 1 to 20 years, inclusive, whose financial eligibility, as determined by the division, does not exceed 150 per cent of the federal poverty level.

SECTION 19. Said subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out clause (d) and inserting in place thereof the following clause:-
(d) persons aged 21 to 64, inclusive, whose financial eligibility, as determined by the division, does not exceed 133 per cent of the federal poverty level; provided, however, that such persons shall meet such other eligibility criteria that the division and the secretary may establish.

SECTION 20. Said subsection (2) of said section 9A of said chapter 118E, as so appearing, is hereby further amended by adding the following clause:-
(j) premium assistance for employer sponsored health insurance for adults whose financial eligibility, as determined by the division, does not exceed 300 per cent of the federal poverty level, are uninsured at the time of application, are not eligible for any other program under this chapter and are not eligible for federal advanced premium tax credits through the health connector because they have access to employer sponsored minimum essential coverage as defined in section 1401 of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended from time to time.

SECTION 21. Subsection (4) of said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out, in line 130, the word “the”, the second time it appears, and inserting in place thereof the following word:- a.

SECTION 22. Subsection (6) of said section 9A of said chapter 118E, as so appearing, is hereby amended by striking out the first and second sentences.

SECTION 23. Said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out, in lines 157, 164, 174, the second time it appears, 179, the second time it appears, 211

and in line 212, the second time it appears, the word “the” and inserting in place thereof, in each instance, the following word:- a.

SECTION 24. Said section 9A of said chapter 118E, as so appearing, is hereby further amended by striking out, in line 182, the words “for expansion beneficiaries”.

SECTION 25. Section 9B of said chapter 118E is hereby repealed.

SECTION 26. Section 10 of said chapter 118E, as appearing in the 2010 Official Edition, is hereby amended by striking out the second paragraph and inserting in place thereof the following paragraph:-
The division may, to the extent permitted by Title XIX or other federal authority, provide medical assistance to pregnant women who are presumptively eligible for the period of time prescribed by federal law or other federal authority. The division shall promulgate regulations to implement this section, which shall require health care providers to notify such pregnant women of the need to file an application for Medicaid and which shall set standards to be used by providers in determining presumptive eligibility.

SECTION 26A. The second paragraph of section 10E of said chapter 118E, as so appearing, is hereby amended by striking out, in line 12, the words, “be limited to” and inserting in place thereof the following words:- include, but shall not be limited to,.

SECTION 27. Section 12 of said chapter 118E is hereby amended by inserting after the words “Title XIX”, in line 21, as so appearing, the following words:- and Title XXI.

SECTION 28. Section 16D of said chapter 118E, as so appearing, is hereby amended by striking out, in line 40, the words “MassHealth Essential” and inserting in place thereof the following words:- MassHealth Family Assistance.

SECTION 29. Section 27 of said chapter 118E, as so appearing, is hereby amended by striking out subsection (c) and inserting in place thereof the following subsection:-
(c) Periodically in accordance with federal law.

SECTION 30. Said section 27 of said chapter 118E, as so appearing, is hereby further amended by inserting after the word “shall”, in line 12, the following words:- , to the extent required by federal law,.

SECTION 31. The definition of “Payments subject to surcharge” in section 64 of chapter 118E, inserted by section 131 of chapter 224 of the acts of 2012, is hereby amended by striking out the words “: (1) Medicaid recipients under age 65; and (2) enrollees in the commonwealth care health

insurance program" and inserting in place thereof the following words:- Medicaid recipients under age 65.

SECTION 32. Clause (ii) of subsection (a) of section 66 of said chapter 118E, as so inserted, is hereby amended by striking out the words "this chapter and the commonwealth care health insurance program under chapter 118H".

SECTION 33. Subsection (b) of said section 66 of said chapter 118E, as so inserted, is hereby amended by striking out the words "and the commonwealth care health insurance programs" and inserting in place thereof the following word:- program.

SECTION 34. Paragraph (3) of subsection (a) of section 69 of said chapter 118E, as so inserted, is hereby amended by striking out the words "or for the commonwealth care health insurance program, established under chapter 118H,".

SECTION 35. Chapter 118H of the General Laws is hereby repealed.

SECTION 36. Subsection (c) of section 46 of chapter 151A of the General Laws, as amended by section 145 of chapter 224 of the acts of 2012, is hereby further amended by striking out clause (7) and inserting in place thereof the following clause:-
(7) to the commonwealth health insurance connector authority, information under an interagency agreement for the administration and enforcement of chapter 176Q.

SECTION 37. Said subsection (c) of said section 46 of said chapter 151A, as so amended, is hereby further amended by striking out clause (8).

SECTION 38. Subsection (a) of subdivision 2 of section 108 of chapter 175 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out paragraph (3) and inserting in place thereof the following paragraph:-
(3) It purports to insure only 1 person, except that a policy, excluding contracts which provide stand-alone dental services, shall insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be considered the policyholder, 2 or more eligible members of that family, including the policyholder, spouse, dependent children and other dependent persons, children during pendency of adoption procedures under chapter 210, children under 26 years of age and children who are mentally or physically incapable of earning their own living, if due proof of the incapacity is received by the insurer within 31 days of the date upon which the coverage would otherwise be terminated; and.

SECTION 39. Section 110 of said chapter 175, as so appearing, is hereby amended by striking out

subdivision (P) and inserting in place thereof the following subdivision:-
(P) A blanket or general policy of insurance described in subdivision (A), (C) or (D), except policies or certificates which provide stand-alone dental services or coverage to Medicare or other governmental programs which shall be delivered, issued or renewed in the commonwealth, shall provide, as benefits to all group members having a place of employment in the commonwealth, coverage to dependent persons under 26 years of age.

SECTION 40. Chapter 176A of the General Laws is hereby amended by striking out section 8BB, as so appearing, and inserting in place thereof the following section:-
Section 8BB. Any subscription certificate under an individual or group nonprofit hospital service agreement, except certificates which provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, that is delivered, issued or renewed in the commonwealth, shall provide, as benefits to all individuals or to all group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

SECTION 41. Chapter 176B of the General Laws is hereby amended by striking out section 4BB, as so appearing, and inserting in place thereof the following section:-
Section 4BB. Any subscription certificate under an individual or group medical service agreement, except certificates that provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, that is delivered or issued or renewed in the commonwealth, shall provide, as benefits to all individual subscribers and members within the commonwealth and to all group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

SECTION 42. Chapter 176G of the General Laws is hereby amended by striking out section 4T, as so appearing, and inserting in place thereof the following section:-
Section 4T. A health maintenance contract, except certificates which provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, shall provide, as benefits to all individuals or to group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age.

SECTION 43. Section 1 of chapter 176J of the General Laws, is hereby amended by striking out the definition of “Eligible dependent”, as so appearing, and inserting in place thereof the following definition:-
“Eligible dependent”, the spouse or child of an eligible person, subject to the applicable terms of the health benefit plan covering such employee. The child of an eligible individual or eligible employee shall be considered an eligible dependent until the end of the child’s twenty-sixth year of age.

SECTION 44. Said section 1 of said chapter 176J is hereby further amended by striking out the definition of “Eligible individual”, as most recently amended by section 30 of chapter 118 of the acts of 2012, and inserting in place thereof the following definition:-
“Eligible individual”, an individual who is a resident of the commonwealth.

SECTION 45. Said section 1 of said chapter 176J is hereby further amended by inserting after the definition of “Financial impairment”, as appearing in the 2010 Official Edition, the following definition:-
“Grandfathered health plan”, any group health plan or health insurance coverage to which 42 U.S.C. section 18011 applies.

SECTION 46. Said section 1 of said chapter 176J is hereby further amended by striking out the definition of “Pre-existing conditions provision”, as so appearing.

SECTION 47. Said section 1 of said chapter 176J is hereby further amended by striking out the definition of “Waiting period”, as so appearing.

SECTION 48. Said chapter 176J is hereby amended by striking out section 3, as amended by section 174 of chapter 224 of the acts of 2012, and inserting in place thereof the following section:-
Section 3. (a) (1) For every health benefit plan issued or renewed to eligible individuals and eligible small groups, including a certificate issued to an eligible individual or eligible small group that evidences coverage under a policy or contract issued or renewed to a trust, association or other entity that is not a group health plan, a carrier shall develop a group base premium rate that is the same for eligible individuals and eligible small groups. In developing these merged market group base premium rates, carriers:
(i) with respect to the group base premium rate developed for eligible individuals and eligible small groups, a carrier shall consider all enrollees in those health plans, other than grandfathered health plans, offered by such carrier to be members of a merged individual and small group risk pool;
(ii) in calculating the premium to be charged to each eligible individual or eligible small group, a carrier shall develop a base premium and use only those rate adjustment factors identified in this section, inclusive, for all insured health benefit plans offered to eligible individuals and eligible small groups, respectively, with all other rating adjustments being prohibited;
(iii) may offer any rate basis types, but rate basis types that are offered to any eligible individual or eligible small group shall be offered to every eligible individual or eligible small group for all coverage issued or renewed; provided, however, that if an eligible small group does not meet a carrier’s minimum or participation contribution requirements, the carrier may separately rate each employee as an eligible individual, as set forth in clause (i);
(iv) shall apply the same rating factors when calculating premiums for eligible individuals as are used when calculating premiums for eligible small groups; and

(v) notwithstanding this section, all carriers offering any coverage to any eligible individual or eligible small group shall make that coverage available to every eligible individual and eligible small group.
(2) The commissioner shall annually file with the United States Department of Health and Human Services to establish a standard age rate adjustment factor table so that the ratio of the highest factor for adults over age 20 compared to the lowest factor for adults over age 20 shall not exceed a ratio of 2-to-1. A carrier that elects to apply standard age rate adjustment factors shall apply them based upon the covered person's age when the coverage period begins.
(3) The commissioner shall annually file with the United States Department of Health and Human Services to establish not more than 7 distinct regions of the state for the purposes of area rate adjustments. A carrier may establish an area rate adjustment for each distinct region, the value of which shall range from .8 to 1.2. If a carrier chooses to apply area rate adjustments, every eligible individual and eligible small group within each area shall be subject to the applicable area rate adjustment.
(4) A carrier shall establish a basis type rate adjustment factor for eligible individuals and eligible small groups which shall vary the rate only on the basis of whether the health benefit plan covers an individual or family. For purposes of this section, the total premium for family coverage must be determined by summing the premiums for each individual family member. With respect to family members under the age of 21, the premiums for not more than the 3 oldest covered children must be taken into account in determining the total family premium.
(5) The commissioner shall annually file with the United States Department of Health and Human Services to establish a standard tobacco use factor. A carrier may apply a tobacco use rate factor in a manner permitted under state and federal law that applies to both eligible small groups and eligible individuals; provided, however, that the carrier uses a certification of tobacco use process that has been approved by the commissioner to determine that eligible individuals and their eligible dependents or eligible small group employees and their eligible dependents have not used tobacco products within the past year.
(6) A carrier may establish a benefit level rate adjustment for all eligible individuals and eligible small groups that shall be expressed as a number. The number shall represent the relative actuarial value of the benefit level, including the health care delivery network, of the health benefit plan issued to that eligible individual or eligible small group as compared to the actuarial value of other health benefit plans within that class of business. If a carrier chooses to establish benefit level rate adjustments, every eligible individual and every eligible small group shall be subject to the applicable benefit level rate adjustment.
(7) A carrier shall not apply any rate adjustment factor to the group base premium rate, other than those set forth herein.
(b) (1) A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its license under chapter 176G, shall be required annually to file a

plan with the connector for its consideration, which meets the requirements for the connector seal of approval pursuant to section 10 of chapter 176Q; provided, however, that the plan shall be filed not later than October 1.

(2) A carrier that, as of the close of any preceding calendar year, has a combined total of 5,000 or more eligible individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans sold, issued, delivered, made effective or renewed to qualified small businesses or eligible individuals pursuant to its authority under chapter 175, 176A or 176B, shall be required annually to file a plan with the connector for its consideration, which meets the requirements for the connector seal of approval pursuant to section 10 of chapter 176Q; provided, however, that the plan shall be filed not later than October 1.

(c) For the purposes of this section, no eligible individual, eligible employee, or eligible dependent shall be considered to be enrolled in a health benefit plan issued pursuant to a carrier's authority under chapter 175, 176A or 176B if the health benefit plan is sold, issued, delivered, made effective or renewed to said eligible employee or eligible dependent as a supplement to a health benefit plan subject to licensure under chapter 176G.

(d) The commissioner may conduct an examination with respect to the derivation of group base premium rates used to develop individual group premiums in order to identify whether any expenses inappropriately increase the cost in relation to the risks of the merged individual and small group health insurance market.

SECTION 49. Subsection (a) of section 4 of said chapter 176J, as most recently amended by section 8 of chapter 3 of the acts of 2013, is hereby further amended by striking out paragraph (2) and inserting in place thereof the following paragraph:-

(2) A carrier shall enroll eligible individuals, as defined by section 1, and eligible individuals, as defined in section 2741 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. section 300gg-41(b), into a health plan if those individuals request coverage within 63 days of termination of any prior creditable coverage. A carrier shall also enroll eligible individuals, as permitted under the Patient Protection and Affordable Care Act, Public Law 111-148, and any rules, regulations and guidances applicable thereto, as amended from time to time. A carrier shall enable any such eligible individual to renew coverage if that coverage is available to other eligible individuals. Coverage shall become effective in accordance with said Patient Protection and Affordable Care Act, and any rules, regulations and guidances applicable thereto, as amended from time to time, subject to reasonable verification of eligibility, and shall be effective through December 31 of that same year. Carriers shall notify any such eligible individuals that:

(i) coverage shall be in effect only through December 31 of the year of enrollment;

(ii) if any such eligible individual is in a health plan with a plan-year deductible or out-of-pocket maximum, an explanation of how that deductible or out-of-pocket maximum and premiums will be impacted for the period between the plan effective date and December 31 of the enrollment year; and

(iii) the next open enrollment period during which any such eligible individual shall have the opportunity to enroll in a health plan that will begin on January 1 of the following calendar year. A carrier shall not impose a pre-existing condition exclusion or waiting period of any duration on a health plan.

SECTION 49A. Subsection (b) of section (4) of said chapter 176J, as appearing in the 2010 Official Edition, is hereby amended by adding the following paragraph:-
(5) Notwithstanding any other provision in this section, with respect to a health benefit plan offered only through a public exchange that pursuant to federal law and regulation does not include pediatric dental benefits, a carrier may deny an eligible individual or eligible small business of any size enrollment in such health benefit plan unless the eligible individual or eligible small business enrolls through the connector. If an eligible individual or eligible small business elects to enroll through the connector, a carrier may not deny that eligible individual or eligible small business enrollment. The carrier shall implement such requirements consistently, treating all eligible individuals and eligible small business in a similar manner.

SECTION 50. Said chapter 176J is hereby further amended by striking out section 5, as so appearing, and inserting in place thereof the following section:-
Section 5. No policy shall exclude an eligible individual, eligible employee or eligible dependent on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition.

SECTION 51. Section 6 of said chapter 176J is hereby amended by striking out subsection (c), as so appearing, and inserting in place thereof the following subsection:-
(c) Notwithstanding any general or special law to the contrary, carriers offering small group health insurance plans, including carriers licensed under chapters 175, 176A, 176B or 176G, shall file small group product base rates and any changes to small group rating factors that are to be effective on January 1 of each year, on or before July 1 of the preceding year. The commissioner shall disapprove any proposed changes to base rates that are excessive, inadequate or unreasonable in relation to the benefits charged. The commissioner shall disapprove any change to small group rating factors that is discriminatory or not actuarially sound. Rates of reimbursement or rating factors included in the rate filing materials submitted for review by the division shall be deemed confidential and exempt from the definition of public records in clause Twenty-sixth of section 7 of chapter 4. The commissioner shall adopt regulations to carry out this section.

SECTION 52. Section 9 of said chapter 176J, as so appearing, is hereby amended by striking out, in lines 64 and 65, the words “, which does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary”.

SECTION 53. Section 12 of said chapter 176J is hereby amended by striking out subsection (h), as appearing in section 179 of chapter 224 of the acts of 2012, and inserting in place thereof the following subsection:-
(h) Any rates offered by a carrier to a certified group purchasing cooperative under this section shall be based on those group base premium rates that apply to individuals and small employer groups enrolling outside the group purchasing cooperative.

SECTION 54. Section 13 of said chapter 176J, as appearing in the 2010 Official Edition, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-
(b) Health benefit plans offered by carriers to group purchasing cooperatives shall: (i) include all state-mandated benefits; (ii) apply open enrollment periods for individuals in the same manner as the carrier applies them for individuals outside the group purchasing cooperative, provided, however, that small business group purchasing cooperatives shall establish rules and open enrollment periods for qualified association members to enter or exit group purchasing cooperatives; (iii) apply continuation of coverage provisions in the same manner as the carrier applies those provisions to small group products offered outside the group purchasing cooperative; (iv) apply managed care practices in the same manner as the carrier applies those practices to small group products offered outside the group purchasing cooperative; and (v) apply rating rules, including rating bands, rating factors and the value of rating factors, in the same manner as the carrier applies those rules to small group products offered outside the group purchasing cooperative.

SECTION 55. Chapter 176N of the General Laws is hereby amended by striking out section 2, as so appearing, and inserting in place thereof the following section:-
Section 2. (a) No health plan shall:
(i) exclude any eligible insured on the basis of age, occupation, actual or expected health condition, claims experience, duration of coverage or medical condition of such person; and
(ii) exclude late enrollees from coverage for more than 12 months from the date of the application for coverage of any late enrollee.
(b) In any circumstance in which more extensive coverage than that provided by clauses (i) and (ii) of subsection (a) is required by any other state or federal law, the health benefit plan shall satisfy such other provision insofar as it requires more extensive coverage.

SECTION 56. Section 1 of chapter 176O of the General Laws is hereby amended by striking out the definition of “Adverse determination”, as so appearing, and inserting in place thereof the following definition:-
“Adverse determination”, based upon a review of information provided by a carrier or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and

level of care, or effectiveness, including a determination that a requested or recommended health care service or treatment is experimental or investigational.

SECTION 57. Said section 1 of said chapter 176O is hereby further amended by striking out the definition of “Grievance”, as so appearing, and inserting in place thereof the following definition:-
“Grievance”, any oral or written complaint submitted to the carrier which has been initiated by an insured, or on behalf of an insured with the consent of the insured, concerning any aspect or action of the carrier relative to the insured, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services, rescission of coverage, quality of care and administrative operations, under the requirements of this chapter.

SECTION 58. Said section 1 of said chapter 176O is hereby further amended by striking out the definition of “Office of patient protection”, as so appearing, and inserting in place thereof the following definition:-
“Office of patient protection”, the office in the health policy commission established by section 16 of chapter 6D, responsible for the administration and enforcement of sections 13, 14, 15 and 16.

SECTION 59. The fourth sentence of subsection (b) of section 2 of said chapter 176O, as amended by section 189 of chapter 224 of the acts of 2012, is hereby further amended by striking out the words “division of health care finance and policy” and inserting in place thereof the following words:- for health information and analysis.

SECTION 60. Said section 2 of said chapter 176O is hereby amended by striking out, in lines 28 and 29, as appearing in the 2010 Official Edition, the words “department of public health established by section 217 of chapter 111” and inserting in place thereof the following words:- health policy commission established by section 16 of chapter 6D.

SECTION 61. Section 6 of said chapter 176O is hereby amended by striking out, in line 54, as so appearing, the words “paragraph (2) of subsection (a) of section 217 of chapter 111” and inserting in place thereof the following words:- paragraph (3) of subsection (a) of section 16 of chapter 6D.

SECTION 62. Said section 6 of said chapter 176O is hereby further amended by striking out, in line 56, as so appearing, the words “in the department of public health” and inserting in place thereof the following words:- or, if applicable, the designated state consumer assistance program.

SECTION 63. Section 7 of said chapter 176O is hereby amended by striking out, in lines 23 and 24, as so appearing, the words “the department of public health under section 25P of chapter 111” and inserting in place thereof the following words:- center for health information analysis.

SECTION 64. Said section 7 of said chapter 176O is hereby further amended by striking out, in lines 45 and 55, as so appearing, the words “department of public health” and inserting in place thereof, in each instance, the following words:- health policy commission.

SECTION 65. Section 13 of said chapter 176O, as so appearing, is hereby amended by striking out, in line 2, the word “provides” and inserting in place thereof the following words:- is compliant with the Patient Protection and Affordable Care Act, Public Law 111-148, as amended from time to time, as well as with any rules, regulations or guidance applicable thereto, and such formal internal grievance process shall provide.

SECTION 66. Subsection (b) of said section 13 of said chapter 176O, as so appearing, is hereby amended by striking out clause (iii) and inserting in place thereof the following 2 clauses:-
(iii) a resolution within 5 days from the receipt of such grievance if submitted by an insured with a terminal illness; and
(iv) a resolution of a claim involving urgently needed services within 72 hours.

SECTION 67. Subsection (c) of said section 13 of said chapter 176O, as so appearing, is hereby amended by adding the following sentence:- Notwithstanding the exhaustion of formal internal grievance process remedies required by section 14, in the event that an insured claims that a carrier failed to properly act on a grievance that is an adverse determination within the time limits required by this section, such claim is immediately eligible for external review.

SECTION 68. Said section 13 of said chapter 176O, as so appearing, is hereby further amended by adding the following subsection:-
(d) An insured may request an expedited review of a grievance and at the same time may request an expedited external review of the grievance pursuant to section 14.

SECTION 69. Section 14 of said chapter 176O, as so appearing, is hereby amended by striking out subsection (a) and inserting in place thereof the following subsection:-
(a) An insured who remains aggrieved by an adverse determination and has exhausted all remedies available from the formal internal grievance process required pursuant to section 13, may seek further review of the grievance by a review panel established by the office of patient protection pursuant to paragraph (5) of subsection (a) of section 16 of chapter 6D. The insured shall pay the first $25 of the cost of the review to said office, which may waive the fee in cases of extreme financial hardship and which shall refund the fee to the insured if the adverse determination is reversed in its entirety. No insured shall be required to pay more than $75 per plan year, regardless of the number of external review requests submitted. The carrier shall be responsible for the remainder of the cost of the review pursuant to regulations promulgated by the executive director of the health policy commission in consultation with the commissioner of insurance. The office of

patient protection shall contract with at least 3 unrelated and objective review agencies through a bidding process and refer grievances to 1 of the review agencies on a random selection basis. The review agencies shall be accredited by a national accrediting organization and shall develop review panels appropriate for the given grievance, which shall include qualified clinical decision-makers experienced in the determination of medical necessity, utilization management protocols and grievance resolution, and shall not have any financial relationship with the carrier making the initial determination. The standard for review of a grievance by such a panel shall be the determination of whether the requested treatment or service is medically necessary, as defined in section 1, and a covered benefit under the policy or contract. The panel shall consider, but not be limited to considering: (i) written documents submitted by the insured, (ii) additional information from the involved parties or outside sources that the review panel deems necessary or relevant, and (iii) information obtained from any informal meeting held by the panel with the parties. The panel shall send final written disposition of the grievance and the reasons therefore, to the insured and the carrier within 45 days of receipt of the request for review. Notwithstanding the requirements of this section, an insured may request an external review of an adverse determination without exhausting the carrier's internal appeals process if the insured is seeking an expedited review or if the carrier failed to meet the time limits specified in section 13.

SECTION 70. Subsection (b) of said section 14 of said chapter 176O, as so appearing, is hereby amended by adding the following 2 sentences:- There shall be a process for the expedited review of grievances. The external review panel set forth in section 14 shall send final written disposition of the grievance, and the reasons therefore, to the insured and the carrier within 72 hours of receipt of the request for such expedited review.

SECTION 71. Said section 14 of said chapter 176O, as so appearing, is hereby further amended by inserting after the word "binding", in line 40, the following words:- on the insured and on the carrier.

SECTION 72. Section 17 of said chapter 176O, as so appearing, is hereby amended by striking out, in line 2, the words "commissioner of public health" and inserting in place thereof the following words:- health policy commission.

SECTION 73. Paragraph (3) of subsection (a) of section 20 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 26 and 27, the words "office of patient protection, established by section 217 of chapter 111," and inserting in place thereof the following words:- office of patient protection, established by section 16 of chapter 6D or, if applicable, the designated state consumer assistance program.

SECTION 74. Section 1 of chapter 176Q of the General Laws is hereby amended by striking out the definition of "Commonwealth care health insurance program", as so appearing.

SECTION 75. Said section 1 of said chapter 176Q is hereby further amended by striking out the definition of “Commonwealth care health insurance program enrollees”, as so appearing.

SECTION 76. Said section 1 of said chapter 176Q is hereby further amended by striking out the definition of “Eligible individual”, as so appearing, and inserting in place thereof the following definition:-
“Eligible individual”, an individual who is a resident of the commonwealth and who is qualified to purchase coverage through the connector pursuant to 42 U.S.C. section 18032(f).

SECTION 77. Said section 1 of said chapter 176Q is hereby further amended by inserting after the definition of “Eligible small group”, as so appearing, the following 2 definitions:-
“Federal advanced premium tax credits”, a payment made pursuant to 26 U.S.C. section 36B on behalf of an eligible individual or eligible child to reduce the value of a health benefit plan premium.
“Federal point-of-service cost-sharing reductions”, a payment made pursuant to 42 U.S.C. section 18071 on behalf of an eligible individual or eligible child to reduce point-of-service cost-sharing expenses which shall include, but not be limited to, copayments, coinsurance and deductibles.

SECTION 78. The definition of “Point-of-service cost-sharing subsidy” in said section 1 of said chapter 176Q, inserted by section 38 of chapter 118 of the acts of 2012, is hereby amended by striking out the word “offset” and inserting in place thereof the following word:- reduce.

SECTION 79. Said section 1 of said chapter 176Q is hereby further amended by striking out the definition of “Premium assistance payment”, as so inserted, and inserting in place thereof the following definition:-
“Premium assistance payment”, a payment made to a carrier or an individual by the connector to reduce the value of a health benefit plan premium paid by the individual.

SECTION 80. Said section 1 of said chapter 176Q is hereby further amended by striking out the definition of “Rating factor”, as appearing in the 2010 Official Edition, and inserting in place thereof the following definition:-
“Rating factor”, characteristics including, but not limited to, age, rate basis type and geography.

SECTION 81. Section 3 of said chapter 176Q is hereby amended by striking out, in lines 4 and 5, the words “, groups and commonwealth care health insurance plan enrollees”, as so appearing, and inserting in place thereof the following words:- and eligible small groups.

SECTION 82. Said section 3 of said chapter 176Q is hereby further amended by striking out, in lines 14 and 15 and lines 30 and 31, the words “, groups and commonwealth care health insurance program enrollees”, as so appearing, and inserting in place thereof, in each instance, the following

words:- and eligible small groups.

SECTION 83. Said section 3 of said chapter 176Q is hereby further amended by striking out, in lines 23 and 24, the words “the commonwealth care health insurance program, established by chapter 118H”, as so appearing, and inserting in place thereof the following words:- premium assistance payments or cost-sharing subsidies.

SECTION 84. Said section 3 of said chapter 176Q is hereby further amended by striking out, in line 33, the word “all”, as so appearing.

SECTION 85. Said section 3 of said chapter 176Q, as so appearing, is hereby further amended by inserting after the word “payments”, in line 38, the following words:- and point-of-service cost-sharing subsidies and, if applicable, federal advanced premium tax credits and federal point-of-service cost-sharing reductions.

SECTION 86. Subsection (a) of said section 3 of said chapter 176Q is hereby amended by striking out paragraph (13), as so appearing, and inserting in place thereof the following paragraph:-
(13) develop a standard application form for eligible individuals and eligible small groups seeking to purchase health insurance through the connector; and.

SECTION 87. Subsection (b) of said section 3 of said chapter 176Q, as amended by section 43 of chapter 118 of the acts of 2012, is hereby amended by inserting after the word “or” the following words:- point-of-service.

SECTION 88. Subsection (m) of said section 3 of said chapter 176Q is hereby further amended by striking out the words “, departments, commissions, authorities or political subdivisions the board considers necessary or appropriate to implement chapters 111M, 118E, 118G 118H and this chapter”, inserted by section 132 of chapter 139 of the acts of 2012, and inserting in place thereof the following words:- , departments, commissions, authorities or political subdivisions the board considers necessary or appropriate to implement chapters 6D, 12C, 15A, 111M, 118E and this chapter.

SECTION 89. Said section 3 of said chapter 176Q, as appearing in the 2010 Official Edition, is hereby amended by striking out subsection (o).

SECTION 90. Subsection (u) of said section 3 of said chapter 176Q, inserted by section 7 of chapter 96 of the acts of 2012, is hereby amended by striking out clause (2) and inserting in place thereof the following clause:- (2) the determination of eligibility of individuals for shopping, receiving federal advanced premium tax credits and qualifying for federal point-of-service cost-sharing reductions

through the Exchange, as provided by federal law; and

SECTION 91. Subsection (a) of section 4 of said chapter 176Q, as appearing in section 45 of chapter 118 of the acts of 2012, is hereby amended by striking out the words ", including all health benefit plans offered through the commonwealth care health insurance program".

SECTION 92. Section 7 of said chapter 176Q is hereby repealed.

SECTION 93. Said chapter 176Q is hereby further amended by striking out section 8, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-
Section 8. (a) The connector shall enter into interagency agreements with the department of revenue, the executive office of health and human services, the department of public health, the executive office of labor and workforce development, the registry of motor vehicles, the department of correction, the center for health information and analysis and any other state agencies, departments, divisions, commissions, authorities or political subdivisions. The agreements shall authorize foregoing agencies, departments, divisions, commissions, authorities and political subdivisions to furnish information, including personal data as defined in chapter 66A, that is necessary for the connector to perform its duties under this chapter, including the determination of an individual's eligibility for federal advanced premium tax credits and federal point-of-service cost-sharing reductions and adjudication of appeals arising from such determinations. Such written agreements shall include provisions permitting the department of revenue to furnish the data available under the wage reporting system established under section 3 of chapter 62E. The department of revenue may furnish the connector with information on the cases of persons so identified, including, but not limited to, name, social security number and other data to ensure positive identification, name and identification number of employer, and amount of wages and gross income received from all sources. The connector shall not utilize any of the data received from the department of revenue for any solicitations or advertising.
(b) The connector may receive and use any information provided pursuant to section 23 of chapter 118E as necessary for the connector to perform the duties under this chapter, including the determination of an individual's eligibility for federal advanced premium tax credits and federal point-of-service cost-sharing reductions and adjudication of appeals arising from such determinations.

SECTION 94. Subsection (a) of section 12 of said chapter 176Q, as appearing in section 49 of chapter 118 of the acts of 2012, is hereby amended by striking out the last sentence.

SECTION 95. Section 15 of said chapter 176Q, as so appearing, is hereby amended by striking out, in lines 14 to 16, inclusive, the words ", the operation and administration of the commonwealth care health insurance program described in chapter 118H".

SECTION 96. Section 1 of chapter 176T of the General Laws, as inserted by section 216 of chapter 224 of the acts of 2012, is hereby amended by striking out the definition of “Public health care payer” and inserting in place thereof the following definition:-
“Public health care payer”, the Medicaid program established in chapter 118E; any carrier or other entity that contracts with the office of Medicaid 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 of the Social Security Act, including prepaid health plans subject to section 28 of chapter 47 of the acts of 1997; the group insurance commission established pursuant to chapter 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

SECTION 97. The first paragraph of section 271 of chapter 127 of the acts of 1999 is hereby amended by striking out the words “, the executor director of the commonwealth health insurance connector authority” inserted by section 226 of chapter 224 of the acts of 2012.

SECTION 98. Said first paragraph of said section 271 of said chapter 127 is hereby further amended by striking out clause (i), as amended by section 227 of said chapter 224 of the acts of 2012, and inserting in place thereof the following clause:-
(i) participants in the Senior Pharmacy program, so-called, pursuant to section 16B of chapter 118E of the General Laws.

SECTION 99. Section 66 of chapter 288 of the acts of 2010 is hereby repealed.

SECTION 100. Section 246 of chapter 224 of the acts of 2012 is hereby repealed.

SECTION 101. Section 253 of said chapter 224 is hereby amended by striking out the words “, the commonwealth care health insurance program established under chapter 118H of the General Laws, any carrier or other entity which contracts with the commonwealth care health insurance program to pay for or arrange for the purchase of health care services”.

SECTION 102. Notwithstanding chapter 176J of the General Laws, for the period from January 1, 2014 through December 31, 2015, carriers may develop the group base premium for eligible small employers in order to vary the group base premium by enrollment or renewal month and shall file the group base premium as part of a rate filing for each calendar quarter.
In calculating the premium to be charged to each eligible small group or eligible individual, carriers may utilize and apply a portion of the following rate adjustment factors, provided, that the carrier has such factor in place as of July 1, 2013, in addition to those rate adjustment factors permitted under said chapter 176J: (i) an industry rate adjustment factor; (ii) a participation rate adjustment factor; (iii) a group size rate adjustment factor; (iv) an intermediary rate adjustment factor; or (v) a group purchasing cooperative rate adjustment factor.

The commissioner of insurance shall promulgate regulations to implement this section, including, but not limited to, regulations setting forth the manner in which carriers may utilize and apply the rate adjustment factors set forth in this section during the period from January 1, 2014 through December 31, 2015, to the extent required by federal law.

SECTION 102A. The commonwealth, by and through the governor or the governor's designee, shall formally request a federal waiver to avoid the adverse effects of rating and rule changes to the Massachusetts merged market, to protect consumers and businesses in the commonwealth and in an effort to maintain current Massachusetts rating and rule requirements including, but not limited to, the number of ratings factors and the number of annual rate settings. All negotiations with any federal agency concerning this waiver shall be conducted in consultation with a member of the house of representatives as appointed by the speaker of the house and a member of the senate as appointed by the senate president. The governor, or the governor's designee shall file a detailed report describing the waiver application and waivers received, along with all documentation, including, but not limited to, all related written and verbal responses from the department of health and human services, with the clerks of the senate and house not later than October 1, 2014. The governor shall report monthly to the joint committee on health care financing and the house and senate committees on ways and means on the status of the waiver request under this section.

SECTION 103. Sections 1, 5 and 93 shall take effect 30 days after the effective date of this act.

SECTION 104. Sections 2 to 4, inclusive, 6 to 49, inclusive, section 50, sections 52 to 92, inclusive, and sections 94 to 101, inclusive, shall take effect on January 1, 2014.

SECTION 105. Section 4A shall take effect on July 1, 2014.

Approved, July 5 , 2013.

HOUSE . . . . . No. 41

Message from His Excellency the Governor recommending legislation relative to supporting employers in the Commonwealth. Labor and Workforce Development. January 8, 2013.

The Commonwealth of Massachusetts

EXECUTIVE DEPARTMENT

STATE HOUSE • BOSTON, MA 02133

(617) 725-4000

DEVAL L. PATRICK

GOVERNOR

TIMOTHY P. MURRAY

LIEUTENANT GOVERNOR

January 8, 2013.

To the Honorable Senate and House of Representatives:

I am filing for your consideration a bill entitled "An Act to Support Employers in the Commonwealth." The legislation is particularly important for the economic success of our state, as it seeks to reduce administrative burdens and costs on Massachusetts businesses.

This legislation will realize these goals by:

- Freezing the Employer Unemployment Insurance (UI) rate for 2013 at "E." Freezing the rate will save employers an estimated $500 million compared to if the rate were allowed to increase to "G" as required by current law.
- Eliminating the Fair Share Contribution Program as of June 30, 2013, thereby lessening the administrative burden many businesses currently face.
- Eliminating the Medical Security Program (MSP) health insurance program by the end of this calendar year and allowing the population typically associated with this program to access subsidized health coverage through our existing state insurance programs, such as MassHealth and those offered at the Health Connector.
- Maintaining a key tenet of our state's 2006 health care reform law – shared responsibility for health care by employers – by repurposing the assessment that

currently funds MSP into an employer contribution that will partially finance state-subsidized health care.

By enacting these provisions, we will keep employers at the table for key health reform policy decisions and help maintain Massachusetts' position as a great state to do business. Accordingly, I urge your prompt and favorable consideration of this legislation.

Respectfully submitted,

DEVAL L. PATRICK,

HOUSE . . . . . No.

The Commonwealth of Massachusetts

In the Year Two Thousand Thirteen

An Act to support employers in the Commonwealth.

Whereas, the deferred operation of this act would tend to defeat its purpose, which is to lower forthwith the cost of unemployment insurance and the costs of operating the Medical Security Trust Program and the Fair Share Program, therefore, it is hereby declared to be an emergency law, necessary for the immediate preservation of the public convenience.

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

SECTION 1. Notwithstanding section 14 of chapter 151A of the General Laws, as appearing in the 2010 Official Edition, the experience rate of an employer qualifying therefor under subsection (b) of said section 14 of said chapter 151A shall be the rate which appears in column "E" in clause (1) of subsection (i) of said section 14 of said chapter 151A for calendar year 2013.

SECTION 2. Section 188 of chapter 149 of the General Laws, as appearing in the 2010 Official Edition, is hereby repealed.

SECTION 3. Section 14G of chapter 151A of the General Laws, as appearing in the 2010 Official Edition, is hereby repealed.

SECTION 4. Section 8A of chapter 23H of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 2-3, the words “Medical Security” and inserting in place thereof the following:- Employer Responsibility.

SECTION 5. Chapter 7 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 61 the following section:-

Section 62. Employer Responsibility Trust Fund

(a)(1) There is hereby established an Employer Responsibility Trust Fund, which shall be administered by the director of the department of unemployment assistance without further appropriation. The purpose of the Trust shall be to fund the provision of subsidized health care for low-income Massachusetts residents. Said trust fund shall consist of health insurance employer responsibility contributions required by subsection (a)(2). Each quarter, DUA shall transfer said funds to MassHealth and the Connector to be used exclusively for providing subsidized health insurance for low-income residents.

(2) Each employer, except those employers who employ five or fewer employees, subject to sections 14, 14A, and 14C of chapter 151A, shall pay, in the same manner and at the same times as the director of the department of unemployment assistance prescribes for the contribution required by said section 14, a health insurance employer responsibility contribution computed by multiplying the wages paid its employees by the health insurance employer responsibility contribution rate of .36 of 1 per cent.

(b) The receipts from such contributions shall be placed in the Employer Responsibility Trust Fund, established in subsection (a), but $1 annually for each employee whose wages determine each employer's total health insurance employer responsibility contribution shall be deposited in

the Catastrophic Illness in Children Relief Fund established by section 2ZZ of chapter 29. Prior to the depositing of the receipts, the director of the department of unemployment assistance may deduct all administrative costs incurred by the department as a result of this section, including an amount as determined by the United States Secretary of Labor in accordance with federal cost rules, but in no calendar year may such deduction exceed 5 per cent of the amounts collected pursuant to this section. For the purpose of accommodating discrepancies between the receipt of revenues and related expenditures, the department may incur obligations and the comptroller may certify payment amounts not to exceed the most recent revenue estimate submitted by the department and approved by the comptroller; provided, however, that the Employer Responsibility Trust Fund shall be in balance by the close of each fiscal year.

(c)(1) For the purposes of this section, the term “wages” shall not include that part of remuneration which, after remuneration equal to the health insurance employer responsibility contribution wage base with respect to employment with such employer has been paid to an individual during the calendar year, is paid to such individual during such year. For the purposes of this paragraph, remuneration shall include remuneration paid to an individual during the calendar year with respect to employment with a transferring employer, as that term is used in subsection (n) of section 14 of chapter 151A.

(2) For the purposes of this section, beginning on the effective date of this section, the term “health insurance employer responsibility contribution wage base” shall have the same meaning as the term "unemployment insurance taxable wage base” in section 14(a)(4) of chapter 151A.

(d)(1) The provisions of this section shall not apply to an employer newly subject to chapter 151A, as defined in paragraphs (2) and (3) of subsection (i) of section 14 of said chapter, until

such employer has been an employer for a minimum of 12 consecutive months, as specified in paragraph (1) of subsection (b) of said section 14.

(2) During the first calendar year in which this section shall apply to an employer newly subject to this chapter pursuant to paragraph (1), such employer's health insurance contribution shall be computed by substituting in subsection (a) the words ".12 of 1 per cent" for the words ".36 of 1 per cent".

(3) During the second calendar year in which this section shall apply to an employer newly subject to this chapter pursuant to paragraph (1), such employer's health insurance contribution shall be computed by substituting in subsection (a) the words ".24 of 1 per cent" for the words ".36 of 1 per cent".

(e) Except where inconsistent with the provisions of this section, the terms and conditions of chapter 151A that are applicable to the payment and collection of contributions or payments in lieu of contributions shall apply to the same extent to the payment of and the collection of such health insurance employer responsibility contribution; provided, however, that such contributions shall not be credited to the employer's account or to the solvency account established pursuant to section 14, 14A, or 14C of chapter 151A.

(f) There shall be a health insurance employer responsibility contribution rate review board composed of the commissioner of medical assistance or designee, the director of the department of unemployment assistance or designee, the executive director of the health connector or designee, and the commissioner of insurance or designee. The rate review board shall meet on or before November 30 of each year to review the previous fiscal year's costs by the Commonwealth of providing subsidized care to low-income residents of Commonwealth. If

the board determines that costs have increased by more than 5% from the previous fiscal year, it may, by a majority vote, adjust the health insurance employer responsibility contribution by no more than 5%.

(g) The director of the department of unemployment assistance, the commissioner of the division of medical assistance, and the executive director of the health connector shall report annually, after the end of each calendar year, to the governor and the senate and house committees on ways and means. The report shall include information about the amount collected in the Employer Responsibility Trust Fund, the amount needed to administer the fund, the amount transferred, and how the funds were used and the method for determining how much was transferred to each program. The report may also make recommendations for changes in the law and regulations governing the fund.

(h) Any employer notified of a liability determination under this section by the director of the department of unemployment assistance may request a hearing on such determination. The request for hearing shall be filed within ten days after mailing of the notice of the determination. If a hearing is requested, said director shall give the employer a reasonable opportunity for a fair hearing before an impartial hearing officer designated by the director. The conduct of such hearing shall be in accordance with the procedures prescribed by subsection (b) of section 39 of chapter 151A. Any employer aggrieved by the decision following such hearing may appeal such decision in accordance with the procedures prescribed by sections 40 to 42, inclusive, of chapter 151A. Unless action is taken under section 40 of chapter 151A, the decision of said director shall be final on all questions of fact and law.

SECTION 6. Section 9 of chapter 111K of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting, after the word “insurance”, in each instance in which it appears, the following:- “employer responsibility”.

SECTION 7. Said section 9 of chapter 111K, as so appearing, is hereby further amended by striking out, in line 5, the word “unemployment”.

SECTION 8. Said section 9 of chapter 111K, as so appearing, is hereby further amended by striking out, in line 7, the words “deputy director of employment and training”, and inserting in place thereof the following words:- director of the department of unemployment assistance.

SECTION 9. Section 1 shall take effect as of January 1, 2013.

SECTION 10. Section 2 shall take effect as of June 30, 2013, provided however, that the department of unemployment assistance shall maintain the Fair Share Unit until all liabilities through June 30, 2013, are accounted for.

SECTION 11. Sections 3 and 5 shall take effect as of the later of December 31, 2013, or such time as the Medical Security Trust Fund has at least a zero balance; provided however, that the department of unemployment assistance is authorized to expend sums beyond December 31, 2013, for the purpose of winding down the Medical Security Program; provided further, however, that, if the Medical Security Program Trust Fund does not have at least a zero balance as of December 31, 2013, the department of unemployment assistance shall submit a report to the governor and the senate and house committees on ways and means certifying projections to bring said trust fund to at least a zero balance and shall be allowed to continue collecting contributions under section 14G of chapter 151A as though it had not been repealed. No funds

shall be collected into the Employer Responsibility Trust Fund until a zero balance in the Medical Security Trust Fund is certified by the department of unemployment assistance.

SECTION 12. Obligations existing or arising from conduct prior to the effective date of this act shall continue to be governed by section 188 of chapter 149 of the General Laws as though it had not been repealed.