HOUSE . . . . . No. 4155

Text of an amendment recommended by the committee on Ways and Means, as changed by the committee on Bills in the Third Reading and as amended by the House, to the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2270). June 5, 2012.

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

By striking out all after the enacting clause and inserting in place thereof the following:—

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, 49, 55 and 86, the words "finance and policy" and inserting in place thereof, in each instance, the following words:— cost and quality.

SECTION 2. Said section 38C of said chapter 3, as so appearing, is hereby amended by striking out, in line 43, the words ", health care quality and cost council".

SECTION 3. 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 division of health care cost and quality.

SECTION 4. Section 16D of chapter 6A of the General Laws, as so appearing, is hereby amended by striking out, in lines 20 and 21, the words "department of public health established

by section 217 of chapter 111" and inserting in place thereof the following words:— division of health care cost and quality established by section 63of chapter 118G.

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 Sections 16J to 16L, inclusive, of said chapter 6A are hereby repealed.

SECTION 6. 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 finance and policy" and inserting in place thereof the following words:— executive director of the division of health care cost and quality.

SECTION 7. Said section 16M of said chapter 6A, as so appearing, is hereby further amended by striking out, in lines 23 and 39, the words "finance and policy" and inserting in place thereof, in each instance, the following words:— cost and quality.

SECTION 8. 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 division of health care cost and quality.

SECTION 9. Subsection (a) of section 16O of said chapter 6A, as so appearing, is hereby amended by striking outthe fifth sentence.

SECTION 10. Subsection (c) of section 4R of chapter 7 of the General Laws, as appearing in section 15 of chapter 68 of the acts of 2011, is hereby amended by striking out the third sentence and inserting in place thereof the following sentence:- The office may enter into an interagency service agreement with the division of health care cost and quality for data collection analysis and technical assistance.

SECTION 11. Chapter 10 of the General Laws is hereby amended by adding the following section:—

Section 75. (a) There shall be established and set upon the books of the commonwealth a separate fund to be known as the Wellness and Prevention 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 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 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 Wellness and Prevention Trust Fund shall support the state's efforts to meet the medical spend benchmark established in section 46 of chapter 118G and 1 or more of the following purposes: (i) reduce rates of the most prevalent and preventable health conditions, including substance abuse; (ii) increase healthy behaviors; (iii) increase the adoption of workplace-based wellness or health management programs that result in positive

returns on investment for employees and employers; (iv) address health disparities; or (v) develop a stronger evidence-base of effective prevention programming.

(d) The commissioner shall annually award not less than 75 per cent of the Wellness and Prevention 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: (i) a municipality or group of municipalities working in collaboration; (ii) a community-based organization working in collaboration with 1 or more municipalities; (iii) a health care provider or a health plan working in collaboration with 1 or more municipalities and a community-based organization; (iv) 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 (v) 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: (i) a plan that defines specific goals for the reduction in preventable health conditions and health care costs over a multi-year period; (ii) the evidence-based programs the applicant shall use to meet the goals; (iii) 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; (iv) any other private funding or private sector participation the applicant anticipates in support of the proposal; (v) a commitment to include women, racial and ethnic minorities and low income individuals; and (vi) 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. 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 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 Wellness and Prevention 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: (i) developing and distributing informational tool-kits for employers, including distributing a model wellness guide developed by the division of insurance; (ii) providing technical assistance to employers implementing wellness programs; (iii) hosting informational forums for employers; (iv) promoting awareness of wellness tax credits provided through the state and federal government, including the wellness subsidy provided by the commonwealth health connector authority; and (v) public information campaigns that quantify the importance of healthy lifestyles, disease prevention, care management and health promotion programs.

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 Wellness and Prevention Trust 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 department of public health; (iii) an itemized list of the funds expended through the competitive grant process and a description of the grantee activities; and (iv) the results of an 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 public health and shall be posted on the department of public health's website.

(h) The department of public health shall 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: (i) 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; (ii) a list of the most costly preventable health conditions in the commonwealth; (iii) a list of evidence-based or promising community-based programs related to the conditions identified in clauses (i) and (ii); and (iv) a list of evidence-based workplace wellness programs or health management programs related to the conditions in clauses (i) and (ii). 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 may promulgate regulations to carry out this section.

SECTION 12. Chapter 12 of the General Lawsis hereby amended by inserting after section 11M the following section:—

Section 11N As used in this section, all terms shall have the same meanings as set forth in section 1 of chapter 118G.

The attorney general shall:

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

(b) in consultation with the division of health care cost and quality, take appropriate action to prevent excess consolidation or collusion of providers, ACOs, or payers and to remedy these or other related anti-competitive dynamics in the health care market;

(c) evaluate the need of the commonwealth to obtain waivers from certain provisions of federal law including, from the federal office of the inspector general, a waiver of the provisions of, or expansion of the “safe harbors” provided for under 42 U.S.C. section 1320a-7b; and a waiver of

143 the provisions of 42 U.S.C. section 1395nn(a) to (e), and where the attorney general deems
144 necessary, provide assistance to support said efforts.

145 SECTION 13. Section 18 of chapter 15A of the General Laws, as appearing in the 2010 Official
146 Edition, is hereby amended by striking out, in lines 14, 17 and 36, the words "finance and
147 policy" and insertingin place thereof, in each instance, the following words:— cost and quality.

148 SECTION 14. Section 7A of chapter 26 of the General Laws, as so appearing, is hereby
149 amended by addingthe following paragraph:—

150 The division shall create a model wellness guide for payers, employers and consumers. The
151 guide shall provide the following information: (1) the importance of healthy lifestyles, disease
152 prevention, and the benefits of care management and health promotion;(2) financial and other
153 incentives for participating in wellness programs; (3) an explanation of the use of technology to
154 provide wellness information and services; (4) the benefits of participating in tobacco cessation
155 programs, weight loss programs, and complying with disease management; (5) a description of
156 the discounts available to employees under the Affordable Care Act; and (6) the ability of payers
157 to reduce premiums by offering incentives to patients with chronic diseases or at high-risk of
158 hospitalization to better comply with prescribed drugs and follow up care.

159 In developing the model guide, the division shall consult with the department of public health
160 and health care stakeholders, including, but not limited to, employers, including representatives
161 of employers with 50 employees or more and representatives of employers with less than 50
162 employees, providers, both for profit and not for profit, health plans and public payers,
163 researchers, consumers, community organizations, and government.

SECTION 15. Section 8H of said chapter 26, as so appearing, is hereby amended by striking out, in lines 60, 64, 71 and 72 and in line 74, the words “finance and policy” and inserting in place thereof,in each instance,the following words:— cost and quality.

SECTION 16. Said section 8H of said chapter 26, as so appearing, is hereby amended by striking out, in lines 55 and 56, and in lines 77 and 78, the words “uncompensated care pool under section 18” and inserting in place thereof, in each case, the following words:— Health Safety Net Trust Fund, established under section 36.

SECTION 17. Chapter 29 of the General Lawsis hereby amended by inserting after section 2EEEE the following 2 sections:—

Section 2FFFF. (a)There is hereby established and set up on the books of the commonwealth a separate fund to be known as the Health Care Workforce Trust Fund, hereinafter called the fund. The fund shall be administered by the health care workforce center which may contract with any appropriate entity to administer the fund or any portion therein. The purposes of the fund shall include:

(i) making awards to health professionals for repayment assistance for medical physician assistant or nursing school loans pursuant to section 60 of chapter 118G, provided that in administering the loan forgiveness grant program, a portion of funds therein shall be granted to applicants performing terms of service in rural primary care sites or family planning sites that meet the criteria of a medically underserved area as determined by the health care workforce center;

(ii) providing employment training opportunities, job placement, career ladder and educational services for currently employed or unemployed health workers who are

seeking new positions or responsibilities within the health care industry with a focus on aligning training and education with industry needs, provided that the fund shall support the distribution of grants to selected health systems, non-profit organizations, labor unions, labor-industry partnerships and others;

(iii) funding residency positions in primary care pursuant to section 61 of chapter 118G; and

(iv) funding 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.

(b) There shall be credited to the fund all monies payable pursuant to (i) funds that are paid to the health care workforce loan repayment program, established under section 60 of chapter 118G, as a result of a breach of contract and private funds contributed from other sources; and (ii) 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.

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

(d) The health care workforce center shall promulgate regulations pursuant to the distribution of monies from the fund to programs listed under subsection (a) and applicant eligibility criteria for said funds.

207 (e) The health care workforce center shall annually, not later than December 31, report to the
208 secretary of administration and finance, the house and senate committees on ways and means,
209 and the joint committee on health care financing regarding the revenues and distribution of
210 monies from the fund in the prior fiscal year.

211 Section 2GGGG. There is hereby established and set up on the books of the commonwealth a
212 separate fund to be known as the Distressed Hospital Trust Fund, which shall be administered by
213 the division of health care cost and quality. Expenditures from the Distressed Hospital Trust
214 Fund shall be dedicated to efforts to improve and enhance the ability of community hospitals to
215 serve populations in need more efficiently and effectively, including, but not limited to, the
216 ability to provide community-based care, clinical support and care coordination services,
217 improve health information technology, or other efforts to create effective coordination of care.

218 The division, in consultation with the Massachusetts Hospital Association, shall develop a
219 competitive grant process for awards to be distributed to distressed hospitals out of said fund.
220 The grant process consideration shall include, but not be limited to, the following factors: (1)
221 payer mix, (2) financial health and its financial needs in the context of being viable in the long
222 term, (3) geographic need, and (4) population need. In assessing financial health, the division
223 shall take into account day's cash on hand, net working capital, earnings before depreciation and
224 amortization, and access to working capital. There shall be an initial transfer of $20,000,000 out
225 of said fund to the wellness and prevention trust fund as established under section 75 of chapter
226 10.

227 SECTION 18. Section 1 of chapter 32 of the General Laws, as appearing in the 2010 Official
228 Edition, is hereby amended by inserting after the word "connector", in line 216, the following

words:— , the division of health care cost and quality established under section 2 of chapter 118G.

SECTION 19. Section 2 of chapter 32A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 11 and 12, the words “commonwealth health insurance connector authority” and inserting in place thereof the following words:- Commonwealth Health Insurance Connector Authority, the division of health care cost and quality established under section 2 of chapter 118G.

SECTION 20. Said chapter 32A is hereby further amended by adding the following 3 sections:-

Section 27. Pursuant to section 51 of chapter 118Gthe commission shall provide a toll-free number and website that enables consumers to request and obtain from the commission in real time the maximum estimated amount the employee shall 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 commission at the time the request is made, including any copayment, deductible, coinsurance or other out of pocket amount for any health care benefits; and a consumer disclosure alerting the employee that these are estimated costs, and that the actual amount the employee will be responsible to pay for a proposed admission, procedure or service may vary.

Section 28. The commission shall attribute every employee to a primary care provider.

Section 29. Pursuant to section 51 of chapter 118G, the commission shall disclose patient-level data including, but not limited to, health care service utilization, medical expenses, demographics, and where services are being provided, to all providers in their network, provided

250 that data shall be limited to patients treated by that provider, in order to aid providers in
251 managing the care of their own patient panel.

252 SECTION 21. Chapter 32B of the General Laws is hereby amended by adding the following 3
253 sections:-

254 Section 30. Pursuant to section 51 of chapter 118G every appropriate public authority which has
255 accepted this chapter shall provide a toll-free number and website that enables consumers to
256 request and obtain from the public authority in real time the maximum estimated amount the
257 subscriber shall be responsible to pay for a proposed admission, procedure or service that is a
258 medically necessary covered benefit, based on the information available to the public authority at
259 the time the request is made, including any copayment, deductible, coinsurance or other out of
260 pocket amount for any health care benefits, and a consumer disclosure alerting the subscriber
261 that these are estimated costs, and that the actual amount the subscriber will be responsible to
262 pay for a proposed admission, procedure or service may vary.

263 Section 31. Every appropriate public authority which has accepted this chapter shall attribute
264 every subscriber to a primary care provider.

265 Section 32. Pursuant to section 51 of chapter 118G, every appropriate public authority which has
266 accepted this chapter shall disclose patient-level data including, but not limited to, health care
267 service utilization, medical expenses, demographics, and where services are being provided, to
268 all providers in their network, provided that data shall be limited to patients treated by that
269 provider, so as to aid providers in managing the care of their own patient panel.

270 SECTION 22. Sections 6D to 6G of chapter 40J of the General Laws are hereby repealed.

SECTION 23. Section 6 of chapter 62 of the General Laws, as most recently amended by section 65 of chapter 68 of the acts of 2011, is hereby further amended by adding the following subsection:—

(s) (1) An employer subject to tax under this chapter which participates in a wellness program may take a credit against the excise imposed under this chapter in an amount equal to 25 per cent of the costs associated with implementing the program, with a maximum credit of $10,000.

(2) The credit shall be allowed if the taxpayer provides the appropriate documentation. The department of revenue, in consultation with the division of insurance and the department of public health, shall promulgate regulations to determine the necessary filings from the taxpayer. These filings shall include proof of using a wellness program qualified under section 206A of chapter 111.

SECTION 24. Section 8B of chapter 62C of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 28 and 29, the words “finance and policy” and inserting in place thereof in each case the following words:— cost and quality

SECTION 25. Section 1 of chapter 62D of the General Laws is hereby amended by striking out, in lines 9 and 10, as so appearing, the words “finance and policy in the exercise of its duty to administer the uncompensated care pool pursuant to ” and inserting in place thereof the following words:— cost and quality in the exercise of its duty to administer the Health Safety Net Trust Fund, established under section 36.

SECTION 26. Said section 1 of chapter 62Dis hereby further amended by striking out, in lines 30 to 35, inclusive, as so appearing, the words “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:— cost and quality, through the health safety net office, on behalf of the Health Safety Net Trust Fund, established under secton 36 of chapter 118G 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.

SECTION 27. Said section 1 of said chapter 62Dis hereby further amended by striking out, in lines 49 and 50, as so appearing, the words "finance and policy" and inserting in place thereof the following words:— cost and quality.

SECTION 28. Section 8 of said chapter 62D, as so appearing, is hereby amended by striking out the second paragraph.

SECTION 29. 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 division of health care cost and quality

SECTION 30. Section 3 of chapter 62E of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words "finance and policy" and inserting in place thereof the following words:— cost and quality.

313 SECTION 31. Section 12 of said chapter 62E, as so appearing, is hereby amended by striking
314 out, in line 20, the words “finance and policy” and inserting in place thereof the following
315 words:—cost and quality.

316 SECTION 32. Said section 12 of said chapter 62E, as so appearing, is hereby further amended
317 by striking out, in line 22, the words “sections 6B, 6C and 18B of chapter 118G” and inserting in
318 place thereof the following words:—sections 6B and 6C of chapter 118G and section 17 of
319 chapter 176Q

320 SECTION 33. Chapter 63 of the General Laws is hereby amended by inserting after section
321 38CC the following section:—

322 Section 38DD. (a) A corporation subject to tax under this chapter which participates in a
323 wellness program may take a credit against the excise imposed under this chapter in an amount
324 equal to 25 per cent of the costs associated with implementing the program, with a maximum
325 credit of $10,000.

326 (b) The credit shall be allowed if the taxpayer provides the appropriate documentation. The
327 department of revenue, in consultation with the division of insurance and the department of
328 public health, shall promulgate regulations to determine the necessary filings from the taxpayer.
329 These filings shall include proof of using a wellness program qualified under section 206A of
330 chapter 111.

331 SECTION 34. Section 1 of chapter 111 of the General Laws, as appearing in the 2010 Official
332 Edition, is hereby amended by inserting before the definition of “Board of health”, the following
333 definition:-

334 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health care
335 provider for health care services.

336 SECTION 35. Said section 1 of said chapter 111, as so appearing, is hereby amended by
337 striking out, in line 38, the words “one hundred and seventy-six G” and inserting in place thereof
338 the following words:- 176G or within an accountable care organization licensed by the division
339 of health care cost and quality under chapter 118J.

340 SECTION 36. Section 4H of said chapter 111, as so appearing, is hereby amended by striking
341 out, in line 20, the words “finance and policy” and inserting in place thereof the following
342 words:— cost and quality

343 SECTION 37. Section 25B of said chapter 111, as so appearing, is hereby amended by striking
344 out, in line 24, the figure “$7,500,000” and inserting in place thereof the following figure:-
345 $10,000,000.

346 SECTION 38. Said section 25B of said chapter 111, as so appearing, is hereby further amended
347 by inserting after the word “has”, in line 35, the following word:- been.

348 SECTION 39. Said section 25B of said chapter 111, as so appearing, is hereby further amended
349 by striking out, in line 43, the figure “$25,000,000”and inserting in place thereof the following
350 figure:- $10,000,000.

351 SECTION 40. Said section 25B of said chapter 111, as so appearing, is hereby further amended
352 by striking out, in lines 47 and 48, the words “, institution for the care of unwed mothers”.

353 SECTION 41. Said section 25B of said chapter 111, as so appearing, is hereby further amended
354 by striking out, in line 49, the words “, which is an infirmary maintained in a town”.

SECTION 42. 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 43. 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 44. 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 45. 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 46. 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 47. Said section 25B of said chapter 111, as so appearing, is hereby further amended by inserting after the letter “(b)”, in line 122, the following words:- for any acute hospital, any increase in bed capacity of more than 4 beds; (c).

SECTION 48. The definition of “Substantial change in services” in section 25B of said chapter 111, as so appearing, is hereby amended by striking outthe last sentence and inserting in place thereof the following sentence:- Notwithstanding any other provisions to the contrary, the department may further define what constitutes a substantial change in service in regulations, including, but not limited to, any changes in its provision of ambulatory surgery services by any facility that provides ambulatory surgery.

SECTION 49. Section 25C of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 4 and 5, the words “or substantially change the service of such facility” and inserting in place thereof the following words:- “, substantially change the service of such facility, or transfer ownership of a facility that requires a determination of need as a condition of initial licensure.

SECTION 50. Said section 25C of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 20 and 118, the words “finance and policy” and inserting in place thereof, in each instance, the following words:— cost and quality.

SECTION 51. Said section 25C of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 42 to 44, inclusive, the words “, in any location other than a health care facility, as such term is defined in section twenty-five B” and inserting in place thereof the following words:- or as determined by the department.

SECTION 52. Said section 25C of said chapter 111, as so appearing, is hereby further amended by striking out, in line 62, the words “magnetic resonance imaging equipment” and inserting in place thereof the following words:- new technology.

SECTION 53. Said section 25C of said chapter 111, as so appearing, is hereby further amended by striking out the fourth paragraph and inserting in place thereof the following paragraph:-

No person or agency of the commonwealth or any political subdivision thereof shall 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 unless the person or agency notifies the department of the person’s or agency’s intent to acquire such equipment and of the use that will be made of the equipment, provided however maintenance or replacement of existing equipment defined as new technology shall not require a review. Such 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 therefor shall be required for any such acquisition (i) if the notice required by this paragraph is not filed in accordance with the requirements of this paragraph, and (ii) if the requirements for exemption under subsection (a) of section 25C1/2; 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 said equipment, unless said person is a physician directly providing services with that equipment; provided, however, that for the purposes of this section, no public advertisement shall be deemed a referral or an influence of referrals; and provided, further, that any person who

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

420 SECTION 54. Section 25C of said chapter 111, as so appearing, is hereby further amended by
421 striking out the fifth, sixth and seventh paragraphs and inserting in place thereof the following 3
422 paragraphs:—

423 A determination of need shall be required for the acquisition of a hospital by any person,
424 agency of the commonwealth or political subdivision thereof. In making any such
425 determination, the department may consider the financial capacity of the prospective licensee to
426 operate the hospital in accordance with applicable laws, whether the transaction will create a
427 significant effect on the availability or accessibility of health care services to the affected
428 communities, the ability of the prospective owner to meet the additional requirements for
429 licensure under section 51G as determined by the department, and the applicant's plan for the
430 provision of community benefits, including the identification and provision of essential health
431 services.

432 The department, in making any determination of need, shall encourage appropriate
433 allocation of private and public health care resources and the development of alternative or
434 substitute methods of delivering health care services so that adequate health care services will be
435 made reasonably available to every person within the commonwealth at the lowest reasonable
436 aggregate cost, may impose terms and conditions as the department reasonably determines are
437 necessary to achieve the purposes and intent of this section, including, but not limited to,
438 maintenance of existing, or addition of new, services and may consider additional factors. The
439 department may also recognize the special needs and circumstances of projects that: (1) are

440 essential to the conduct of research in basic biomedical or health care delivery areas or to the
441 training of health care personnel; (2) are unlikely to result in any increase in the clinical bed
442 capacity or outpatient load capacity of the facility; and (3) are unlikely to cause an increase in the
443 total patient care charges of the facility to the public for health care services, supplies, and
444 accommodations, as such charges shall be defined from time to time in accordance with section 5
445 of chapter 409 of the acts of 1976. Any determination of need shall be guided by the state health
446 plan.

447 Applications for such determination shall be filed with the department, together with such
448 other forms and information as shall be prescribed by, or acceptable to, the department. A
449 duplicate copy of any application together with supporting documentation therefor, shall be a
450 public record and kept on file in the department. The department may require a public hearing on
451 any application. A reasonable fee, established by the department, shall be paid upon the filing of
452 such application; provided, that in no event shall such fee exceed one-fifth of 1 per cent of the
453 capital expenditures, if any, proposed by the applicant or 0.2 per cent of the acquisition costs of a
454 transfer of ownership.

455 SECTION 55. Said chapter 111is hereby further amended by inserting after section 25E the
456 following section:—

457 Section 25E½. (a) There shall be in the department a division of health planning, in this section
458 called the division. The division shall develop a state health plan, and may amend the plan as
459 necessary.

460 (b) There shall be in the department a health planning council consisting of the commissioner or
461 a designee, the director of the office of Medicaid or a designee, the executive director of the

division of health care cost and quality or a designee, the secretary of health and human services or a designee, the director of the division, and 5 members appointed by the governor, of whom at least 1 shall be a health economist; at least 1 shall have experience in health policy and planning, and at least 1 shall have experience in health care market planning and service line analysis and one of whom shall be members of labor organizations selected from a list of 3 names submitted by the President of the Massachusetts AFL-CIO. The health planning council shall advise the division and shall oversee and issue the state health plan developed by the division.

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

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

SECTION 56. Section 25G of said chapter 111, as appearing in the 2010 Official Edition, is hereby amended by adding the following sentence:— Any violation of such provisions also shall constitute grounds to refuse to accept, review or consider an application for a determination of need by the facility, its affiliates, including a parent, subsidiary, umbrella organization or another facility in the same health system or organization, or grounds for additional terms and conditions on any subsequent application for a determination of need by the facility or its

483 affiliates, including a parent, subsidiary, umbrella organization or another facility in the same
484 health system or organization for a minimum of 5 years.

485 SECTION 57. Sections 25L to 25N, inclusive, of said chapter 111 are hereby repealed.

486 SECTION 58. Section 25P of said chapter 111 is hereby repealed.

487 SECTION 59. Section 51 of said chapter 111 , as appearing in the 2010 Official Edition, is
488 hereby amended by striking out, in lines 36 and 46, the words “finance and policy” and inserting
489 in place thereof, in each instance, the following words:— cost and quality.

490 SECTION 60. Section 51G of said chapter 111, as so appearing, is hereby amended by inserting
491 after the word “ services,”, the first time it appears, in line 38, the following words:- conduct a
492 public hearing on the closure of said essential services or of the hospital. The department shall.

493 SECTION 61. Said section 51G of said chapter 111, as so appearing, is hereby further amended
494 by striking out, in line 40, the word “area,” and inserting in place thereof the following words:-
495 area and shall.

496 SECTION 62. Said section 51G of said chapter 111, as so appearing, is hereby further amended
497 by striking out, in line 41, the words “service, and” and inserting in place thereof the following
498 words:- service. In order to.

499 SECTION 63. Said section 51G of said chapter 111, as so appearing, is hereby further amended
500 by inserting after the word “services”, in line 44, the following words:- , the department shall
501 require the hospital to continue providing the essential service unless the department finds that
502 such continuation would impose an undue financial burden on the hospital.

503 SECTION 64. Said section 51G of said chapter 111, as so appearing, is hereby further amended
504 by adding the following paragraph:-

505 (7) Any violation of the requirements under this section also shall constitute grounds for
506 refusing to grant or renew, modifying or revoking the license of a health care facility or of any
507 part thereof, grounds to refuse to accept, review or consider an application for a determination of
508 need by the facility, its affiliates, including a parent, subsidiary, umbrella organization or another
509 facility in the same health system or organization, or grounds for additional terms and conditions
510 on any subsequent application for a determination of need by the facility or its affiliates,
511 including a parent, subsidiary, umbrella organization or another facility in the same health
512 system or organization for a minimum of 5 years.

513 SECTION 65. Section 51H of said chapter 111, as so appearing, is hereby amended by striking
514 out subsection (c), contained in lines 68 to 75, inclusive, and inserting in place thereof the
515 following subsection:—

516 (c) The department, through interagency service agreements, shall transmit data collected under
517 this section to the Betsy Lehman center for patient safety and medical error reduction and the
518 division of health care cost and quality established under chapter 118G for publication on its
519 consumer health information website and for reporting quality data to providers. Any facility
520 failing to comply with this section may: (i) be fined up to $1,000 per day per violation; (ii) have
521 its license revoked or suspended by the department; or (iii) be fined up to $1,000 per day per
522 violation and have its license revoked or suspended by the department.

523 SECTION 65A. Chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is
524 hereby amended by inserting after section 51H the following section:–

525

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

527 requires otherwise, have the following meanings:-

528

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

530 underlying condition of the patient.

531

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

533 before, during and after a given procedure to decrease the possibility of adverse effects and other

534 patient harm by articulating standards of care.

535

536 “Facility,” a hospital; institution maintaining an Intensive Care Unit; institution providing

537 surgical services, or clinic providing ambulatory surgery.

538

539 (b) The department shall encourage the development and implementation of checklists of care

540 that prevent adverse events and reduce healthcare-associated infection rates. The department

541 shall develop model checklists of care, which may be implemented by facilities; provided

542 however, that facilities may develop and implement checklists independently.

543

544 (c) Facilities shall report data and information relative to their use or non-use of checklists to the

545 department and the Betsy Lehman center for patient safety and medical error reduction. The

546 department may consider facilities that use similar programs to be in compliance. Reports shall

547 be made in the manner and form established by the department. The department shall publicly
548 report on individual hospitals' compliance rates."

549 SECTION 66. Said chapter 111 is hereby further amended by inserting after section 51H the
550 following 2 new sections:-

551 Section 51I. (a) As used in this section, the following word shall, unless the context clearly
552 requires otherwise, have the following meaning:--

553 "Facility", any hospital, as defined in section 52, or clinic conducted by a hospital, as licensed
554 under section 51, which receives a separate on-site review survey by the joint commission on the
555 accreditation of healthcare organizations.

556 (b) A facility that is either affiliated or owned by a system shall negotiate separate contracts by
557 facility with public and private payers.

558 (c) Each facility that is subject to this section that is within a larger system shall establish
559 separate negotiating teams.

560 (d) Every facility that is subject to this section shall establish a firewall mechanism that prevents
561 the separate contract negotiating teams from sharing any information that would inhibit them
562 from competing with each other and with other hospitals and physician practice groups.

563 (e) Contracts between a facility and carrier may not be contingent on entering into a contract
564 with another health care provider within a system.

565 (f) Contracts between a facility and carrier may not make the availability of any price or term for
566 a contract contingent on the carrier entering into a contract with another health care facility.

567 (g) Separate negotiations shall apply for both inpatient and outpatient services.

568 (h) The department and the office of the attorney general shall have the authority to enforce the
569 requirements of this section.

570 (i) If a system or one or more of its facilities (1) has entered into one or more alternative
571 payment methodology contracts, as defined in section 1 of chapter 118G, and (2) receives
572 payment through an alternative payment methodology for at least 50 per cent of the total number
573 of patients of such system who are assigned to primary care providers within such system, the
574 provisions of this section shall not apply to such system or to any facility within such system.

575

576 (j) Health care facilities shall negotiate under the requirements of this section at the time of
577 renewal or expiration of their current contracts with payers.

578 Section 51J. As used in this section the following words shall, unless the context clearly requires
579 otherwise, have the following meanings:-

580 "Adverse Event", injury to a patient resulting from a medical intervention, and not to the
581 underlying condition of the patient.

582 "Checklist of Care", pre-determined steps to be followed by a team of healthcare providers
583 before, during, and after a given procedure to decrease the possibility of patient harm by
584 standardizing care.

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

587 The department shall encourage the development and implementation of checklists of care that
588 prevent adverse events and reduce healthcare-associated infection rates. The department shall
589 develop model checklists of care, which may be implemented by facilities; provided however,
590 facilities may develop and implement checklists independently.

591 Facilities shall report data and information relative to their use or non-use of checklists to the
592 department and the Betsy Lehman Center for Patient Safety and Medical Error Reduction.
593 Reports shall be made in the manner and form established by the department.

594

595 SECTION 67. Said chapter 111 is hereby further amended by inserting after section 53G the
596 following section:—

597 Section 53H. (a) There shall be a division of certification of physician organizations located
598 within the department.

599 (b) The division shall have the following powers and duties:

600 (1) to develop and administer a program for certification of physician organizations including,
601 but not limited to, establishing levels of certification;

602 (2) to make, adopt, amend, repeal, and enforce such rules and regulations consistent with law as
603 it deems necessary for the protection of public health, safety, and welfare and for the proper
604 administration and enforcement of its responsibilities;

605 (3) to collect reasonable fees established pursuant to section 3B of chapter 7 to support the
606 division's operations and administration;

607 (4) to establish, in consultation with the boards of professional licensure, a standardized
608 electronic system for the public reporting of provider license information; and

609 (5) to perform such other functions and duties as may be required to carry out this section.

610 .

611 (c) A physician organization shall be defined as a group of physicians contracting as a single
612 entity rather than in their individual capacities unless the group consists of 24 physicians or
613 fewer; provided however, that any licensed entity including, but not limited to, hospitals and
614 clinics that directly employ physicians shall not be required to register as a physician
615 organizations.

616 (d) No later than 30 days after an application has been filed, the division may require the
617 physician organization to provide additional information to complete or supplement the filing.

618 (e) Within 45 days of receipt of a complete application, the division shall complete its review of
619 the application and send written notice to the applicant, with a copy to the division of insurance,
620 explaining its decision to: (1) issue the certification as applied for; (2) issue the certification as
621 applied for but with conditions that restrict certain material changes without prior approval; (3)
622 issue a certification at a lower certification level than applied for; (4) reject the application for
623 failure to comply with the requirements of the application process, with instructions that the
624 application may be resubmitted within 10 days; or (5) deny the application.

625 (f) Any physician organization whose application has been rejected or denied, or who has been
626 issued a certificate with conditions or at a lower level than applied for, may request an
627 adjudicatory hearing pursuant to chapter 30A within 21 days of the division's decision. The

628 division shall notify the attorney general and the division of insurance upon receipt of such
629 hearing request. Said hearing shall be conducted within 30 days of the division's receipt of the
630 hearing request. The attorney general may intervene in a hearing under this subsection and may
631 require the production of additional information or testimony. The commissioner shall issue a
632 written decision within 30 days of the conclusion of the hearing.

633 (g) A physician organization aggrieved by said written decision may, within 20 days of said
634 decision, file a petition for review in the Suffolk superior court. Review by the supreme judicial
635 court on the merits shall be limited to the record of the proceedings before the commissioner and
636 shall be based upon the standards set forth in paragraph (7) of section 14 of chapter 30A.

637 SECTION 68. Section 62M of said chapter 111 , as appearing in the 2010 Official Edition, is
638 hereby amended by striking out, in line 13, the words "finance and policy" and inserting in place
639 thereof the following words:— cost and quality.

640 SECTION 69. Section 67C of said chapter 111 , as so appearing, is hereby amended by striking
641 out, in line 8, the words "finance and policy" and inserting in place thereof the following
642 words:— cost and quality.

643 SECTION 70. Section 69H of said chapter 111 , as so appearing, is hereby amended by striking
644 out, in line 3, the words "finance and policy" and inserting in place thereof the following
645 words:— cost and quality.

646 SECTION 71. Section 72P of said chapter 111 , as so appearing, is hereby amended by striking
647 out, in lines 20 and 21, the words "finance and policy" and inserting in place thereof the
648 following words:— cost and quality.

SECTION 72. Section 72Q of said chapter 111 , as so appearing, is hereby amended by striking out, in line 3, the words “finance and policy” and inserting in place thereof the following words:— cost and quality.

SECTION 73. Section 78 of said chapter 111 s, as so appearing, is hereby amended by striking out, in line 20, the words “finance and policy” and inserting in place thereof the following words:— cost and quality.

SECTION 74. Section 78A of said chapter 111, as so appearing, is hereby amended by striking out, in line 14, the words “finance and policy” and inserting in place thereof the following words:— cost and quality.

SECTION 75. Section 79 of said chapter 111 , as so appearing, is hereby amended by striking out, in line 9, the words “finance and policy” and inserting in place thereof the following words:— cost and quality.

SECTION 76. Section 80 of said chapter 111 , as so appearing, is hereby amended by striking out, in lines 5 and 6, the words “finance and policy” and inserting, in each instance, in place thereof the following words:— cost and quality.

SECTION 77. Section 82 of said chapter 111 , as so appearing, is hereby amended by striking out, in line 23, the words “finance and policy” and inserting in place thereof the following words:— cost and quality.

SECTION 78. Section 88 of said chapter 111 , as so appearing, is hereby amended by striking out, in line 16, the words “finance and policy” and inserting in place thereof the following words:— cost and quality.

670 SECTION 79. Section 116A of said chapter 111, as so appearing, is hereby amended by striking
671 out, in line 2, the words “finance and policy” and inserting in place thereof the following
672 words:— cost and quality.

673 SECTION 80. Said chapter 111 is hereby further amended by inserting after section 206 the
674 following section:-

675 Section 206A. The commissioner shall provide a wellness seal of approval to a wellness program
676 that is actuarially equivalent to the programs defined in section 206. The commissioner, in
677 consultation with the commissioner of the department of revenue, shall create a form that
678 indicates an employer is using an approved wellness program.

679 SECTION 81. Section 217 of said chapter 111 , is hereby repealed.

680 SECTION 82. Said chapter 111 is hereby further amended adding the following 2 sections:—

681 Section 225. (a) Upon request by a patient or prospective patient, a health care provider shall
682 disclose the charges, and if available, the allowed amount, or where it is not possible to quote a
683 specific amount in advance due to the health care provider’s inability to predict the specific
684 treatment or diagnostic code, the estimated charges or estimated allowed amount for a proposed
685 admission, procedure or service.

686 (b) A health care provider referring a patient to another provider that is part of or represented by
687 the same provider organization as defined in section 53H shall disclose that the providers are part
688 of or represented by the same provider organization. As used in this section, “allowed amount”,
689 shall mean the contractually agreed upon amount paid by a carrier to a health care provider for
690 health care services provided to an insured.

691 Section 226. (a) As used in this section, the following words shall, unless the context clearly
692 requires otherwise, have the following meanings:—

693 "Hospital", a hospital licensed under section 51, the teaching hospital of the University of
694 Massachusetts Medical School, a licensed private or state-owned and state-operated general
695 acute care hospital, or an acute care unit within a state-operated facility; provided, however, that
696 "hospital" shall not include a licensed non-acute care hospital classified as an inpatient
697 rehabilitation facility, an inpatient substance abuse facility, or a long term care hospital by the
698 federal Centers for Medicare and Medicaid Services.

699 "Nurse", a registered nurse licensed under section 74 of chapter 112 or a licensed practical nurse
700 licensed under section 74A of said chapter 112.

701 "Mandatory Overtime", any hours worked by a nurse in a hospital setting to deliver patient care,
702 beyond the predetermined and regularly scheduled number of hours that the hospital and nurse
703 have agreed that the employee shall work, provided that in no case shall such predetermined and
704 regularly scheduled number of hours exceed 12 hours in any 24 hour period.

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

708 (c) Pursuant to paragraph (b), whenever there is an emergency situation where the safety of a
709 patient requires its use and when there is no reasonable alternative, the facility shall, before
710 requiring mandatory overtime, make a good faith effort to have overtime covered on a voluntary
711 basis. Mandatory overtime shall not be used as a practice for providing appropriate staffing for
712 the level of patient care required.

713 (d) The department in consultation with the Massachusetts Nurses Association and the
714 Massachusetts Hospital Association, and other organizations, shall determine what constitutes an
715 "emergency situation." The department shall solicit feedback through public hearing.

716 (e) Following shall report all instances of mandatory overtime, and the circumstances requiring
717 its use, to the department. Such reports shall be public documents.

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

721 (g) The provisions of this section are intended as a remedial measure to protect the public health
722 and the quality and safety of patient care, and shall not be construed to diminish or waive any
723 rights of the nurse pursuant to any other law, regulation, or collective bargaining agreement. The
724 refusal of a nurse to accept work in excess of the limitations set forth in this section shall not be
725 grounds for discrimination, dismissal, discharge or any other employment decision.

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

729 SECTION 83. Section 10 of chapter 111K of the General Laws, as appearing in the 2010
730 Official Edition, is hereby amended by striking out, in lines 2 and 3, the words "finance and
731 policy" and inserting in place thereof the following words:— cost and quality.

732 SECTION 84. The first paragraph of section 2 of chapter 112 of the General Laws, as so
733 appearing, is hereby amended by inserting after the second sentence the following:—The board

734 shall require, as a standard of eligibility for licensure, that applicants demonstrate proficiency in
735 the use of computerized physician order entry, e-prescribing, electronic health records and other
736 forms of health information technology, as determined by the board. As used in this section,
737 proficiency, at a minimum shall mean that applicants demonstrate the skills to comply with the
738 "meaningful use" requirements, so-called, as set forth in 45 C.F.R. Part 170. This section shall
739 not apply to any applicant board certified and practicing as a pathologist.

740 SECTION 85. Said chapter 112 is hereby further amended by inserting after section 2Cthe
741 following section:—

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

746 SECTION 86. Section 9C of said chapter 112, as so appearing, is hereby amended by striking
747 out the definition of "Physician assistant" and inserting in place thereof the following definition:-

748 "Physician assistant," a person who is duly registered and licensed by the board.

749 SECTION 87. The first paragraph of section 9E of said chapter 112 , as so appearing, is hereby
750 amended by striking out the last sentence.

751 SECTION 88. The third paragraph of said section 9E of said chapter 112 , as so appearing, is
752 hereby amended by striking out the last sentence.SECTION 89. Said chapter 112 is hereby
753 further amended by inserting after section 80H the following section:—

754 Section 80I. When a provision of law or rule requires a signature, certification, stamp,
755 verification, affidavit or endorsement by a physician, when relating to physical or mental health,
756 that requirement may be fulfilled by a nurse practitioner practicing under section 80B. Nothing
757 in this section shall be construed to expand the scope of practice of nurse practitioners. This
758 section shall not be construed to preclude the development of mutually agreed upon guidelines
759 between the nurse practitioner and supervising physician under section 80E of chapter 112.

760 SECTION 90. Chapter 118E of the General Laws is hereby amended by inserting after section
761 9E the following section:-
762
763 Section 9F. (a) As used in this section, the following words shall have the following meanings:-
764
765 "Dual eligible", or "dually eligible person", any person age 21 or older and under age 65 who is
766 enrolled in both Medicare and MassHealth.
767
768 "Integrated care organization" or "ICO", a comprehensive network of medical, health care and
769 long term services and supports providers that integrates all components of care, either directly
770 or through subcontracts and has been contracted with by the Executive Office of Health and
771 Human Services and designated an ICO to provide services to dually eligible individuals
772 pursuant to this section.
773
774 (b) Members of the MassHealth dual eligible pilot program on ICOs or any successor program
775 integrating care for dual eligible persons shall be provided an independent community care
776 coordinator by the ICO or successor organization, who shall be a participant in the member's

777 care team. The community care coordinator shall assist in the development of a long term
778 support and services care plan. The community care coordinator shall:
779 (1) participate in initial and ongoing assessments of the health and functional status of the
780 member, including determining appropriateness for long term care support and services, either in
781 the form of institutional or community-based care plans and related service packages necessary
782 to improve or maintain enrollee health and functional status;
783 (2) arrange and, with the agreement of the member and the care team, coordinate the provision of
784 appropriate institutional and community long term supports and services, including assistance
785 with the activities of daily living and instrumental activities of daily living, housing, home-
786 delivered meals, transportation, and under specific conditions or circumstances established by
787 the ICO or successor organization, authorize a range and amount of community-based services;
788 and
789 (3) monitor the appropriate provision and functional outcomes of community long term care
790 services, according to the service plan as deemed appropriate by the member and the care team;
791 and track member satisfaction and the appropriate provision and functional outcomes of
792 community long term care services, according to the service plan as deemed appropriate by the
793 member and the care team.
794 (c) The ICO or successor organization shall not have a direct or indirect financial ownership
795 interest in an entity that serves as an independent care coordinator. Providers of institutional or
796 community based long term services and supports on a compensated basis shall not function as
797 an independent care coordinator, provided however that the secretary may grant a waiver of this
798 restriction upon a finding that public necessity and convenience require such a waiver. For the
799 purposes of this section, an organization compensated to provide only evaluation, assessment,

800 coordination, skills training, peer supports and fiscal intermediary services shall not be
801 considered a provider of long term services and supports.

802 SECTION 91. Section 12 of said chapter 118E , as appearing in the 2010 Official Edition, is
803 hereby amended by striking out, in line 12, the words “finance and policy” and inserting in place
804 thereof the following words:— cost and quality.

805 SECTION 92. Section 13 of said chapter 118E, as so appearing, is hereby amended by striking
806 out, in line 3, the words “finance and policy” and inserting in place thereof the following
807 words:— cost and quality.

808 SECTION 93. Section 13B of said chapter 118E, as so appearing, is hereby amended by striking
809 out, in lines 11 to 13, inclusive, the words “the Massachusetts health care quality and cost
810 council established under section 16K of chapter 6A and”.

811 SECTION 94. Section 14 of said chapter 118E , as so appearing, is hereby amended by striking
812 out, in lines 5 and 66, in each case, the words “finance and policy” and inserting in place thereof
813 the following words:— cost and quality.

814 SECTION 95. Subsection (e) of section 22 of said chapter 118E , as so appearing, is hereby
815 amended by striking out, in lines 44 and 45, the words “finance and policy” and inserting in
816 place thereof the following words:— cost and quality.

817 SECTION 96. Said chapter 118E is hereby further amended by adding the following 9
818 sections:—

819 Section 63. In connection with the governor’s fiscal year 2015 budget recommendation, the
820 secretary of administration and finance and the director of Medicaid shall submit to the

821 legislature a plan to ensure greater predictability and stability in the rates paid by Medicaid to
822 health care providers. The plan shall include the establishment of a Medicaid reserve fund or a
823 similar mechanism.

824 Section 64. The office of Medicaid shall establish rates paid to providers at least 60 days prior to
825 the time such rates take effect.

826 Section 65. Rates paid by Medicaid to acute care hospitals and to providers of primary care
827 services shall provide an additional 2 per cent bonus above other adjustments to the annual rate
828 calculations, including updates for inflation, case-mix adjustments, base year updates, and any
829 other improvements to the rate methodology; provided, however, that only those hospitals and
830 providers that have demonstrated to the satisfaction of the division of health care cost and quality
831 a significant transition to the use of alternative payment methodologies shall be eligible for the 2
832 per cent bonus payment; provided further, that said bonus to qualifying hospitals and providers
833 shall apply to all health care services provided to medical assistance recipients including
834 outpatient, inpatient and behavioral health services, including, but not limited to, those under
835 primary care clinician and mental health and substance abuse plans or through a health
836 maintenance organization under contract. The division of health care cost and quality shall
837 establish by regulation what constitutes a significant use of alternative payment methodologies
838 by a provider. The office of Medicaid shall not offset the 2 per cent bonus by reducing Medicaid
839 base rates to acute hospitals or providers of primary care.

840 Section 66. The office of Medicaid shall develop an accountable care organization and patient-
841 centered medical home innovation project that employs alternative payment methodologies
842 including, but not limited to, bundled payments, global payments, shared savings and other

843 innovative methods of paying for health care services. The office of Medicaid shall take actions
844 necessary to amend its managed care organization and primary care clinician contracts as
845 necessary to include such contracts in the innovation project. In developing the innovation
846 project that employes alternative payment methodologies, the office of Medicaid shall ensure
847 payment and quality metric alignment with existing accountable care demonstrations
848 implemented by the Centers for Medicare and Medicaid Services. The office of Medicaid shall
849 consult with stakeholders including, but not limited to, the division of health care cost and
850 quality, hospitals or hospital associations, carriers or carrier associations, consumer groups,
851 physician or physician associations, and other health care providers on such projects and
852 alternative payment methodologies under this section. The office of Medicaid shall also consult
853 with safety net providers including high Medicaid and low-income public payer hospitals to
854 ensure that said alternative payment methodologies (1) support the state's efforts to improve
855 health, care delivery and cost-effectiveness; (2) include incentives for high quality, coordinated
856 care, including wellness services, primary care services and behavioral health services; (3)
857 include a risk adjustment element based on health status; (4) to the extent possible, include a risk
858 adjustment element that takes into account functional status, socioeconomic status or cultural
859 factors; (5) preserve the use of intergovernmental transfer financing mechanisms by
860 governmental acute public hospitals consistent with the Medical Assistance Trust Fund
861 provisions in effect as of fiscal year 2012; and (6) recognize the unique circumstances and
862 reimbursement requirements of high Medicaid disproportionate share hospitals and other safety
863 net providers with concentrated care in government programs.

864 Section 67. To the greatest extent possible, the office of Medicaid shall pay for health care using
865 the accountable care organization or patient-centered medical home model of delivering health
866 care services.

867 In making the transition to ACOs and patient-centered medical homes, the office of Medicaid
868 shall achieve the following benchmarks to the maximum extent feasible:

869 (i) Not later than January 1, 2013, the office of Medicaid shall pay for health care based on
870 the ACO or medical home health care delivery model for no fewer than 25 per cent of its
871 enrollees that are not also covered by other health insurance coverage, including Medicare and
872 employer-sponsored or privately purchased insurance.

873 (ii) Not later than January 1, 2014, the office of Medicaid shall pay for health care based on
874 the ACO or medical home health care delivery model for no fewer than 50 per cent of its
875 enrollees that are not also covered by other health insurance coverage, including Medicare and
876 employer-sponsored or privately purchased insurance.

877 (iii) Not later than January 1, 2015, the office of Medicaid shall pay for health care based on
878 the ACO or medical home health care delivery model for no fewer than 80 per cent of its
879 enrollees that are not also covered by other health insurance coverage, including Medicare and
880 employer-sponsored or privately purchased insurance.

881 Section 68. To the extent that the office of Medicaid continues to pay acute care hospitals and
882 other providers on a fee-for-service basis, the office shall establish, in cases in which the office
883 believes it would enhance the health care quality and assist in achieving the state wide health
884 care cost growth targets under section 46 of chapter 118G, a shared savings payment program.

885 Section 69. The office of Medicaid and the commonwealth health insurance connector authority
886 shall, to the greatest extent possible, work to ensure that the same health care plans are offered
887 through MassHealth and Commonwealth Care so that persons transitioning between different
888 payers do not have to switch health plans. Persons deemed eligible for medical benefits pursuant
889 to section 9A of chapter 118E or section 2 of chapter 118H shall continue to be eligible for
890 assistance and remain enrolled in said programs for a period of 12 months, until the member's
891 annual eligibility review, if the member would otherwise be determined ineligible due to excess
892 countable income but otherwise remain eligible.

893 Section 70. The office of Medicaid shall attribute every beneficiary to a primary care provider.

894 SECTION 97. Chapter 118G of the General Laws is hereby amended by striking out section 1,
895 as appearing in the 2010 Official Edition, and inserting in place thereof the following section:—

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

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

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

904 "Accountable care organization" or "ACO", an accountable care organization licensed under
905 chapter 118J.

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

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

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

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

914 “Alternative payment contract”, an agreement between a payer and an ACO or other provider in
915 which reimbursement available under the agreement is pursuant to alternative payment
916 methodologies for services provided by an ACO or other provider. The contract shall include at
917 least some performance based quality measures with associated financial rewards or penalties, or
918 both.

919 “Alternative payment methodologies or methods”, methods of payment defined in regulations
920 adopted by the division that compensate ACOs and other providers for the provision of health
921 care services, including, but not limited to, shared savings arrangements, shared risk
922 arrangements, bundled payments for acute care episodes, bundled payments for chronic diseases,
923 and global payments, as defined in regulations adopted by the division. Alternative payment
924 methodologies may include a risk adjustment for health status as defined in regulations adopted
925 by the division. No payment based solely on the fee-for-service methodology shall be considered
926 an alternative payment; provided, however, that alternative payment methodologies may include
927 fee-for-service payments which are settled or reconciled with a global payment.

928 “Ambulatory surgical center”, any distinct entity that operates exclusively for the purpose of
929 providing surgical services to patients not requiring hospitalization and meets the requirements
930 of the federal Health Care Financing Administration for participation in the Medicare program.

931 “Ambulatory surgical center services”, services described for purposes of the Medicare program
932 pursuant to 42 U.S.C. section 1395k(a)(2)(F)(I). These services include facility services only and
933 do not include surgical procedures.

934 “Bad debt”, an account receivable based on services furnished to any patient which: (i) is
935 regarded as uncollectable, following reasonable collection efforts consistent with regulations of
936 the division, which regulations shall allow third party payers to negotiate with hospitals to collect
937 the bad debt of its enrollees; (ii) is charged as a credit loss; (iii) is not the obligation of any
938 governmental unit or of the federal government or any agency thereof; and (iv) is not free care.

939 “Bundled payment for acute care episode,” a single payment arrangement that pays for all the
940 services, including, but not limited to, physician, professional and hospital services, associated
941 with a clinically defined episode of care.

942 “Bundled payment for a chronic disease,” a single payment arrangement that pays for the care of
943 a chronic disease including, but not limited to, all physician, professional, hospital services
944 related to that condition for a specified period of time.

945 “Case mix”, the description and categorization of a hospital’s patient population according to
946 criteria approved by the division including, but not limited to, primary and secondary diagnoses,
947 primary and secondary procedures, illness severity, patient age and source of payment.

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

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

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

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

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

960 “Disproportionate share hospital”, any acute hospital that exhibits a payer mix where a minimum
961 of 63 per cent of the acute hospital’s gross patient service revenue is attributable to Title XVIII
962 and Title XIX of the Federal Social Security Act, other government payors and free care.

963 “Division”, the division of health care cost and quality established by section 2.

964 “DRG”, a diagnosis related group, which is a patient classification scheme which provides a
965 means of relating the type of patients a hospital treats, such as its case mix, to the cost incurred
966 by the hospital.

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

970 “Emergency bad debt”, bad debt related to emergency services provided by an acute hospital to
971 an uninsured individual.

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

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

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

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

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

987 “Executive director”, the executive director of the division of health care cost and quality.

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

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

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

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

998 “Free care”, the following medically necessary services provided to individuals determined to be
999 financially unable to pay for their care, in whole or in part, pursuant to applicable regulations of
1000 the division: (i) services provided by acute hospitals; (ii) services provided by community health
1001 centers; and (iii) patients in situations of medical hardship in which major expenditures for health
1002 care have depleted or can reasonably be expected to deplete the financial resources of the
1003 individual to the extent that medical services cannot be paid, as determined by regulations of the
1004 division.

1005 “General health supplies, care or rehabilitative services and accommodations”, all supplies, care
1006 and services of medical, optometric, dental, surgical, podiatric, psychiatric, therapeutic,
1007 diagnostic, rehabilitative, supportive or geriatric nature, including inpatient and outpatient
1008 hospital care and services, and accommodations in hospitals, sanatoria, infirmaries, convalescent
1009 and nursing homes, retirement homes, facilities established, licensed or approved pursuant to the
1010 provisions of chapter 111B and providing services of a medical or health-related nature, and

1011 similar institutions including those providing treatment, training, instruction and care of children
1012 and adults; provided, however, that rehabilitative service shall include only rehabilitative
1013 services of a medical or health-related nature which are eligible for reimbursement under the
1014 provisions of Title XIX of the Social Security Act.

1015 “Global payment”, a payment arrangement where spending targets are established for a
1016 comprehensive set of health care services for the care that a defined population of patients may
1017 receive in a specified period of time. Global payments generally place providers at some
1018 financial risk for both the occurrence of medical conditions as well as the management of those
1019 conditions. Global payments must at a minimum include primary care in addition to other
1020 comprehensive health care services as further defined by the division.

1021 “Governmental mandate”, a state or federal statutory requirement, administrative rule,
1022 regulation, assessment, executive order, judicial order or other governmental requirement that
1023 directly or indirectly imposes an obligation and associated compliance cost upon a provider to
1024 take an action or to refrain from taking an action in order to fulfill the provider’s contractual duty
1025 to a procuring governmental unit.

1026 “Governmental unit”, the commonwealth, any department, agency board or commission of the
1027 commonwealth, and any political subdivision of the commonwealth.

1028 “Gross inpatient service revenue”, the total dollar amount of a hospital’s charges for inpatient
1029 services rendered in a fiscal year.

1030 “Gross patient service revenue”, the total dollar amount of a hospital’s charges for services
1031 rendered in a fiscal year.

1032 "Gross state product", the total annual output of the Massachusetts economy as measured by the
1033 U.S. Department of Commerce, Bureau of Economic Analysis, Gross Domestic Product by State
1034 series.

1035 “Growth rate of potential gross state product”, the long-run average growth rate of the
1036 commonwealth’s economy, ignoring fluctuations due to the business cycle.

1037 “Health benefit plan”, as defined in section 1 of chapter 176J.

1038 “Health care provider”, a provider of medical or health services or any other person or
1039 organization, including, but not limited to, an ACO, that furnishes, bills, or is paid for health care
1040 service delivery in the normal course of business.

1041 “Health care services”, supplies, care and services of medical, surgical, optometric, dental,
1042 podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative,
1043 supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital
1044 care and services; services provided by a community health center home health and hospice care
1045 provider, or by a sanatorium, as included in the definition of “hospital” in Title XVIII of the
1046 federal Social Security Act, and treatment and care compatible with such services or by a health
1047 maintenance organization.

1048 “Health insurance company”, a company, as defined in section 1 of chapter 175, which engages
1049 in the business of health insurance.

1050 “Health insurance plan”, the medicare program or an individual or group contract or other plan
1051 providing coverage of health care services and which is issued by a health insurance company, a
1052 hospital service corporation, a medical service corporation or a health maintenance organization.

1053 “Health maintenance organization”, a company which provides or arranges for the provision of
1054 health care services to enrolled members in exchange primarily for a prepaid per capita or
1055 aggregate fixed sum as further defined in section 1 of chapter 176G.

1056 “Health status adjusted total medical expenses”, the total cost of care for the patient population
1057 associated with a provider group based on allowed claims for all categories of medical expenses
1058 and all non-claims related payments to providers, adjusted by health status, and expressed on a
1059 per member per month basis, as calculated under section 6 and the regulations promulgated by
1060 the commissioner.

1061 “Hospital”, any hospital licensed under section 51 of chapter 111, the teaching hospital of the
1062 University of Massachusetts Medical School and any psychiatric facility licensed under section
1063 19 of chapter 19.

1064 “Hospital agreement”, an agreement between a nonprofit hospital service corporation and the
1065 hospital signatory thereto approved by the division under section 5 of chapter 176A.

1066 “Hospital service corporation”, a corporation established for the purpose of operating a nonprofit
1067 hospital service plan as provided in chapter 176A.

1068 “Managed health care plan”, a health insurance plan which provides or arranges for, supervises
1069 and coordinates health care services to enrolled participants, including plans administered by
1070 health maintenance organizations and preferred provider organizations.

1071 “Medicaid program”, the medical assistance program administered by the division of medical
1072 assistance pursuant to chapter 118E and in accordance with Title XIX of the Federal Social
1073 Security Act or any successor statute.

1074 “Medical assistance program”, the medicaid program, the Veterans Administration health and
1075 hospital programs and any other medical assistance program operated by a governmental unit for
1076 persons categorically eligible for such program.

1077 “Medically necessary services”, medically necessary inpatient and outpatient services as
1078 mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall
1079 not include: (i) non-medical services, such as social, educational and vocational services; (ii)
1080 cosmetic surgery; (iii) canceled or missed appointments; (iv) telephone conversations and
1081 consultations; (v) court testimony; (vi) research or the provision of experimental or unproven
1082 procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-
1083 surgery hormone therapy; and (vii) the provision of whole blood; and provided, however, that
1084 administrative and processing costs associated with the provision of blood and its derivatives
1085 shall be payable.

1086 “Medicare program”, the medical insurance program established by Title XVIII of the Federal
1087 Social Security Act.

1088 “Medical service corporation”, a corporation established for the purpose of operating a nonprofit
1089 medical service plan as provided in chapter 176B.

1090 “Medical spend”, the total cost of care for the patient population associated with a provider
1091 group, based on allowed claims for all catagories of medical expenses and all non-claims related
1092 payments to providers during a calendar year as further defined by the division in regulation.

1093 “Non-acute hospital”, any hospital which is not an acute hospital.

1094 “Non-providing employer”, an employer of a state-funded employee, as defined in this section;
1095 provided, however, that the term “non- providing employer” shall not include:—

1096 (i) an employer who complies with chapter 151F for such employee;

1097 (ii) an employer that is signatory to or obligated under a negotiated, bona fide collective
1098 bargaining agreement between such employer and bona fide employee representative which
1099 agreement governs the employment conditions of such person receiving free care;

1100 (iii) an employer who participates in the Insurance Partnership Program; or

1101 (iv) an employer that employs not more than 10. For the purposes of this definition, an employer
1102 shall not be considered to pay for or arrange for the purchase of health care services provided by
1103 acute hospitals and ambulatory surgical centers by making or arranging for any payments to the
1104 uncompensated care pool.

1105 “Patient”, any natural person receiving health care services from a hospital.

1106 “Patient-centered medical home”, a model of health care delivery designed to provide a patient
1107 with a single point of coordination for all their health care, including primary, specialty, post-
1108 acute and chronic care, which is (i) patient-centered; (ii) comprehensive, integrated and
1109 continuous; and (iii) delivered by a team of health care professionals to manage a patient’s care,
1110 reduce fragmentation, and improve patient outcomes.

1111 “Payer”, any entity, other than an individual, that pays providers for the provision of health care
1112 services. It shall include both governmental and private entities, but excludes ERISA plans.

1113 “Payments from non-providing employers”, all amounts paid to the Uncompensated Care Trust
1114 Fund or the General Fund or any successor fund by non-providing employers.

1115 “Pediatric hospital”, an acute care hospital which limits services primarily to children and which
1116 qualifies as exempt from the Medicare Prospective Payment system regulations.

1117 “Pediatric specialty unit”, a pediatric unit of an acute care hospital in which the ratio of licensed
1118 pediatric beds to total licensed hospital beds as of July 1, 1994, exceeded 0.20. In calculating that
1119 ratio, licensed pediatric beds shall include the total of all pediatric service beds, and the total of
1120 all licensed hospital beds shall include the total of all licensed acute care hospital beds, consistent
1121 with Medicare’s acute care hospital reimbursement methodology as put forth in the Provider
1122 Reimbursement Manual Part 1, Section 2405.3G.

1123 “Performance incentive payment” or “pay-for-performance”, an amount paid to a provider by a
1124 payer for achieving certain quality measures as defined in this chapter. Performance incentive
1125 payments shall comply with this chapter, regulations of the division, and the contract between a
1126 provider and a payer.

1127 “Performance penalty”, a reduction in the payments made by a payer to a provider for failing to
1128 achieve certain quality measures as herein defined. Performance penalties and their
1129 implementation shall comply with this chapter, any regulations of the division, and the contract
1130 between a provider and a payer.

1131 “Physician”, a medical or osteopathic doctor licensed to practice medicine in the commonwealth.

1132 “Physician organizations”, a physician organization certified under section 53H of chapter 111.

1133 “Primary care physician”, a physician who has a primary specialty designation of internal
1134 medicine, general practice, family practice, pediatric practice or geriatric practice.

1135 “Primary care provider”, a health care professional qualified to provide general medical care for
1136 common health care problems, who supervises, coordinates, prescribes, or otherwise provides or
1137 proposes health care services, initiates referrals for specialist care, and maintains continuity of
1138 care within the scope of practice.

1139 “Private health care payer”, (i) a carrier authorized to transact accident and health insurance
1140 under chapter 175, (ii) a nonprofit hospital service corporation licensed under chapter 176A, (iii)
1141 a nonprofit medical service corporation licensed under chapter 176B, (iv) a dental service
1142 corporation organized under chapter 176E, (v) an optometric service corporation organized under
1143 chapter 176F, (vi) a self-insured plan, to the extent allowable under federal law governing health
1144 care provided by employers to employees, or (vii) a health maintenance organization licensed
1145 under chapter 176G.

1146 “Provider” or “health care provider”, a provider of medical or health services and any other
1147 person or organization, including an ACO, that furnishes, bills, or is paid for health care service
1148 delivery in the normal course of business.

1149 “Public health care payer”, the Medicaid program established in chapter 118E; any carrier or
1150 other entity that contracts with the office of Medicaid or the commonwealth health insurance
1151 connector to pay for or arrange the purchase of health care services on behalf of individuals
1152 enrolled in health coverage programs under Titles XIX or XXI, or under the commonwealth care
1153 health insurance program, including prepaid health plans subject to the provisions of section 28
1154 of chapter 47 of the acts of 1997; the group insurance commission established under chapter
1155 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

1156 “Public payer-dependent non-acute hospital”, any non-acute hospital that (1) was certified by the
1157 Secretary of the United States Department of Health and Human Services as participating in the
1158 federal medicare program pursuant to clause (iv) of 42 USC section 1395ww (d)(1)(B) on
1159 January 1, 1996; (2) is not owned by the commonwealth; and (3) exhibits a payor mix in which a
1160 minimum of 15 per cent of such hospital’s gross patient service revenue, as reported on the RSC-
1161 403 for hospital fiscal year 1994, was attributable to Title XIX of the federal Social Security Act.
1162 Such term does not include a hospital that was reimbursed for services provided to individuals
1163 entitled to medical assistance under chapter 118E for fiscal year 1996 pursuant to a contract
1164 between the hospital and the division of medical assistance.

1165 “Publicly aided patient”, a person who receives hospital care and services for which a
1166 governmental unit is liable, in whole or in part, under a statutory program of public assistance.

1167 “Purchaser”, a natural person responsible for payment for health care services rendered by a
1168 hospital.

1169 “Quality measures”, the standard quality measure set as defined by the division in section 68.

1170 “Relative prices”, the contractually negotiated amounts paid to providers by each private and
1171 public carrier for health care services, including non-claims related payments and expressed in
1172 the aggregate relative to the payer’s network-wide average amount paid to providers, as
1173 calculated under section 6 of chapter 118G and regulations promulgated by the commissioner.

1174 “Resident”, a person living in the commonwealth, as defined by the division by regulation;
1175 provided, however, that such regulation shall not define a resident as a person who moved into
1176 the commonwealth for the sole purpose of securing health insurance under this chapter.

1177 Confinement of a person in a nursing home, hospital or other medical institution shall not in and
1178 of itself, suffice to qualify such person as a resident.

1179 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a patient
1180 for a charge.

1181 “Secretary”, the secretary of health and human services.

1182 “Self-employed”, a person who, at common law, is not considered to be an employee and whose
1183 primary source of income is derived from the pursuit of a bona fide business.

1184 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
1185 business, which is not a health insurance plan, and in which the business is liable for the actual
1186 costs of the health care services provided by the plan and administrative costs.

1187 “Self-insured group”, a self-insured or self-funded employer group health plan.

1188 “Small business”, a business in which the total number of full-time employees, when averaged
1189 on an annual basis, does not exceed 50, including only of the self-employed.

1190 “Social service program”, a social, mental health, mental retardation, habilitative, rehabilitative,
1191 substance abuse, residential care, adult or adolescent day care, vocational, employment and
1192 training, or elder service program or accommodations, purchased by a governmental unit or
1193 political subdivision of the executive office of health and human services, but excluding any
1194 program, service or accommodation that: (a) is reimbursable under a Medicaid waiver granted
1195 under section 1115 of Title XI of the Federal Social Security Act; or (b) is funded exclusively by
1196 a federal grant.

1197 “Social service program providers”, providers of social service programs in the commonwealth.

1198 “Sole community provider”, any acute hospital which qualifies as a sole community provider
1199 under Medicare regulations or under regulations promulgated by the executive office, which
1200 regulations shall consider factors including, but not limited to, isolated location, weather
1201 conditions, travel conditions, percentage of Medicare, Medicaid and free care provided and the
1202 absence of other reasonably accessible hospitals in the area; provided, that such hospitals shall
1203 include those which are located more than 20 miles driving distance from other such hospitals in
1204 the commonwealth and which provide services for at least 60 per cent of their primary service
1205 area.

1206 “Specialty hospital”, an acute hospital which qualifies for an exemption from the medicare
1207 prospective payment system regulations or any acute hospital which limits its admissions to
1208 patients under active diagnosis and treatment of eyes, ears, nose and throat or to children or
1209 patients under obstetrical care.

1210 “State-funded employee”, any employed person, or dependent of such person, who receives, on
1211 more than 3 occasions during any hospital fiscal year, health services paid for as free care; or any
1212 employed persons, or dependents of such persons, of a company that has 5 or more occurrences
1213 of health services paid for as free care by all employees in aggregate during any fiscal year. An
1214 occurrence shall include all healthcare related services incurred during a single visit to a health
1215 care professional.

1216 “State institution”, any hospital, sanatorium, infirmary, clinic and other such facility owned,
1217 operated or administered by the commonwealth, which furnishes general health supplies, care or
1218 rehabilitative services and accommodations.

1219 “Third party administrator”, an entity that administers payments for health care services on
1220 behalf of a client in exchange for an administrative fee.

1221 “Third party payer”, an entity including, but not limited to:; (i) Title XVIII and Title XIX
1222 programs, (ii) other governmental payers, (iii) insurance companies, (iv) health maintenance
1223 organizations and (v) nonprofit hospital service corporations. Third party payer shall not include
1224 a purchaser responsible for payment for health care services rendered by a hospital, either to the
1225 purchaser or to the hospital.

1226 “Title XIX”, Title XIX of the Federal Social Security Act, 42 U.S.C. 1396 et seq., or any
1227 successor statute enacted into federal law for the same purposes as Title XIX.

1228 “Uninsured patient”, a patient who is not covered by a health insurance plan, a self-insurance
1229 health plan, or a medical assistance program.

1230 SECTION 98. Said chapter 118G is hereby further amended by striking out section 2, as so
1231 appearing, and inserting in place thereof the following section:—

1232 Section 2. (a) There shall be in the executive office of health and human services, but not under
1233 its control, a state agency known as the division of health care cost and quality, in this chapter
1234 called the division.

1235 (b) There shall be a board, with duties and powers established by this chapter, which shall govern
1236 the division. The board shall consist of 11 members: the secretary of administration and finance,

1237 ex officio; the secretary of health and human services, ex officio; 6 members appointed by the
1238 governor, 1 of whom shall be a health care economist, 1 of whom shall be an expert in hospital
1239 administration and finance, 1 of whom shall be an expert in the development and utilization of
1240 innovative medical technologies and treatments for patient care, 1 of whom shall be an expert in
1241 women's health, 1 of whom shall be a purchaser of health insurance, and 1 of whom shall be a
1242 primary care physician licensed to practice in the commonwealth; and 3 members appointed by
1243 the attorney general, 1 of whom shall be a practicing nurse licensed to practice in the
1244 commonwealth, 1 of whom shall be an expert in health plan administration and finance, 1 of
1245 whom shall be an expert representative from a labor organization representing the health care
1246 workforce, and 1 of whom shall be an expert in a health care consumer advocacy and privacy
1247 protection. The governor shall designate the chairperson of the board. All appointments shall
1248 serve a term of 3 years, but a person appointed to fill a vacancy shall serve only for the unexpired
1249 term. An appointed member of the board shall be eligible for reappointment. The board shall
1250 annually elect 1 of its members to serve as vice-chairperson. Each member of the board serving
1251 ex officio may appoint a designee under section 6A of chapter 30.

1252 (c) Five members of the board shall constitute a quorum, and the affirmative vote of 5 members
1253 of the board shall be necessary and sufficient for any action taken by the board. No vacancy in
1254 the membership of the board shall impair the right of a quorum to exercise all the rights and
1255 duties of the division. Members shall serve without pay, but shall be reimbursed for actual
1256 expenses necessarily incurred in the performance of their duties.

1257 (d) Any action of the division may take effect immediately and need not be published or posted
1258 unless otherwise provided by law. Meetings of the division shall be subject to sections 18 to 25,
1259 inclusive, of chapter 30A; but, said sections shall not apply to any meeting of members of the

division serving ex officio in the exercise of their duties as officers of the commonwealth if no matters relating to the official business of the division are discussed and decided at the meeting. The division shall be subject to all other provisions of said chapter 30A, and records pertaining to the administration of the division shall be subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the division shall be considered to be public funds for purposes of chapter 12A. Except as otherwise provided in this section, the operations of the division shall be subject to chapter 268A and chapter 268B.

(e) The chairperson shall appoint an executive director. The executive director shall supervise the administrative affairs and general management and operations of the division and also serve as secretary of the division, 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 division necessary to the functioning of the division. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director of the division. Sections 45, 46 and 46C of chapter 30 shall not apply to any employee of the division. 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 division; and

1280 (v) undertake any other activities necessary to implement the powers and duties set forth in this
1281 chapter.

1282 (f) The members of the board shall be deemed to be directors for purposes of the fourth
1283 paragraph of section 3. Chapter 268A shall apply to all board members except that the division
1284 may purchase from, sell to, borrow from, contract with or otherwise deal with any organization
1285 in which any board member is in anyway interested or involved; provided, however, that such
1286 interest or involvement shall be disclosed in advance to the board and recorded in the minutes of
1287 the proceedings of the board; and provided further, that no member shall be deemed to have
1288 violated section 4 of said chapter 268A because of his or her receipt of his or her usual and
1289 regular compensation from his or her employer during the time in which the member participates
1290 in the activities of the board.

1291 (g) The executive director shall appoint and may remove such agents and subordinate officers as
1292 the executive director may deem necessary and may establish such subdivisions within the
1293 division as he deems appropriate to fulfill the purposes set forth in this chapter, chapter 118I, and
1294 chapter 118J.

1295 The division shall adopt and amend rules and regulations, in accordance with chapter 30A, for
1296 the administration of its duties and powers and to effectuate the provisions and purposes of this
1297 chapter. Such regulations shall be adopted, after notice and hearing, only upon consultation with
1298 representatives of nonprofit hospital service corporations established under chapter 176A,
1299 elected representatives of health systems agencies designated pursuant to Title XV of the federal
1300 public health service act, representatives of companies authorized to sell accident and health
1301 insurance under chapter 175 and the Massachusetts Hospital Association.

1302 SECTION 99. Section 2A of chapter 118G of the General Laws, as so appearing, is hereby
1303 amended by striking out the first sentence and inserting in place thereof the following
1304 sentence:— The secretary, in consultation with the division, shall establish rates of payment for
1305 health care services.

1306 SECTION 100. Said chapter 118G is hereby further amended by striking out section 3, as so
1307 appearing, and inserting in place thereof the following section:-

1308 Section 3. For the purposes set forth in this chapter, the board is authorized and empowered as
1309 follows:

1310 (a) to develop a plan of operation for the division. The plan of operation shall include, but not be
1311 limited to:

1312 (1) implementation of procedures for operations of the division; and

1313 (2) implementation of procedures for communications with the executive director;

1314 (b) to make, amend and repeal rules and regulations for the management of its affairs;

1315 (c) to make contracts and execute all instruments necessary or convenient for the carrying on of
1316 its business;

1317 (d) to acquire, own, hold, dispose of, and encumber personal property and to lease real property
1318 in the exercise of its powers and the performance of its duties;

1319 (e) to seek and receive any grant funding from the federal government, departments or agencies
1320 of the commonwealth, and private foundations;

1321 (f) to enter into and execute instruments in connection with agreements or transactions with any
1322 federal, state or municipal agency or other public institution or with any private individual,
1323 partnership, firm, corporation, association or other entity, including contracts with professional
1324 service firms as may be necessary in its judgment, and to fix their compensation;

1325 (g) to maintain a prudent level of reserve funds to protect the solvency of any trust funds under
1326 the operation and control of the division; and

1327 (h) to enter into interdepartmental agreements with any other state agencies the board deems
1328 necessary to implement the provisions of this chapter.

1329 SECTION 101. Said chapter 118Gis hereby further amended by inserting after section 3 the
1330 following 2 sections:—

1331 Section 3A. (a) The division shall work with other state agencies including, but not limited to,
1332 the department of public health, the department of mental health, the division of medical
1333 assistance and the division of insurance to collect and publish data concerning the cost of health
1334 insurance in the commonwealth and the health status of individuals, hold annual hearings
1335 concerning health care provider and payer costs and cost trends, and to provide an analysis of
1336 health care spending trends with recommendations for strategies to promote an efficient health
1337 delivery system. The division shall make available actual costs of health care services, as
1338 supplied by each provider, to the general public in the manner specified in section 57.

1339 (b) The division shall have the power to design and to revise, consistent with this chapter, a basic
1340 schedule of health care services that enrollees in any health insurance program implemented by
1341 the division shall be eligible to receive. Such covered services shall include those which typically
1342 are included in employer-sponsored health benefit plans in the commonwealth. The division may

1343 promulgate schedules of covered health care services which differ from the basic schedule and
1344 which apply to specific classes of enrollees. The division may promulgate a schedule of premium
1345 contributions, co-payments, co-insurance, and deductibles for said programs, including reduced
1346 premiums based on a sliding fee, and other fees and revise them from time to time, subject to the
1347 approval of the division of insurance; and provided, however, that such schedule shall provide
1348 for such enrollees to pay 100 per cent of such premium contributions if their income
1349 substantially exceeds the non-farm poverty guidelines of the United States Office of
1350 Management and Budget.

1351 (c) The division shall adopt and amend rules and regulations, in accordance with chapter 30A,
1352 for the administration of its duties and powers and to effectuate the provisions and purposes of
1353 this chapter. Such regulations shall be adopted, after notice and hearing, only upon consultation
1354 with; (1) representatives of nonprofit hospital service corporations established under chapter
1355 176A; (2) elected representatives of health systems agencies designated pursuant to Title XV of
1356 the federal public health service act; (3) representatives of companies authorized to sell accident
1357 and health insurance under chapter 175, and (4) the Massachusetts Hospital Association.

1358 Section 3B. The division shall implement the reform of the health care delivery and payment
1359 system in the commonwealth in accordance with this chapter. The board shall: (i) monitor the
1360 establishment of ACOs; (ii) monitor the development of patient-centered medical homes; (iii)
1361 monitor the adoption of alternative payment methodologies and health care delivery systems by
1362 providers; and (iv) ensure the consistent and effective use by providers of quality measures to
1363 promote patient-centered, timely, high-quality and safe care for individuals in the
1364 commonwealth.

1365 SECTION 102. Section 4 of said chapter 118G , as so appearing, is hereby amended by striking
1366 out, in line 1, the word “commissioner” and inserting in place thereof the following words:—
1367 executive director.

1368 SECTION 103. Section 5 of said chapter 118G is hereby repealed.

1369 SECTION 104. Section 6 of said chapter 118G , as appearing in the 2010 Official Edition, is
1370 hereby amended by striking out the first sentence and inserting in place thereof the following
1371 sentence:— The division may promulgate such regulations as necessary to ensure the uniform
1372 reporting of revenues, charges, costs, and utilization of health care services and other such data
1373 as the division may require of institutional providers and their parent organizations and any other
1374 affiliated entities, non-institutional providers including, but not limited to, physician group and
1375 physician organization entities, and ACOs; provided, that physicians in contracting units of 24
1376 physicians or fewer shall be exempt from said reporting.

1377 SECTION 105. Said section 6 of said chapter 118G, as so appearing, is hereby further amended
1378 by inserting after the word “r group”the first time it appears, in line 52 and in line 76, the first
1379 time it appears, the following words:— , accountable care organization, as defined in chapter
1380 118J, physician organization, as defined in section 53H of chapter 111.

1381 SECTION 106. Said section 6 of said chapter 118G , as so appearing, is hereby further
1382 amended by inserting after the word “hospital”, in lines 54 and 77, the following words:— ,
1383 accountable care organization, as defined in chapter 118J, physician organization, as defined in
1384 section 53H of chapter 111.

1385 SECTION 107. Said section 6½ of said chapter 118G, as so appearing, is hereby further
1386 amended by striking out, in lines 50 and 51, the words “and (x) any witness identified by the

1387 attorney general" and inserting in place thereof the following:— (x) accountable care
1388 organizations from separate regions of the state; (xi) physician organizations from at least 3
1389 separate regions of the state; and (xii) any witness identified by the attorney general.

1390 SECTION 108. Said section 6½ of said chapter 118G , as so appearing, is hereby further
1391 amended by inserting after the word "technology", in line 62, the following words:—and the
1392 impact of price transparency on prices.

1393 SECTION 109. Said section 6½ of said chapter 118G, as so appearing, is hereby further
1394 amended by insertingafter the word "practices", in line 69, the following words:— , the impact
1395 of price transparency on prices.

1396 SECTION 110. Subsection (g) of said section 6½ of said chapter 118G, as so appearing, is
1397 hereby amended by striking out the third sentence.

1398 SECTION 111. Said section 6½ of saidchapter 118G , as so appearing, is hereby further
1399 amended by adding the following paragraph:—

1400 (h) As used in this section, "provider," shall mean any person, corporation partnership,
1401 governmental unit, state institution, accountable care organization, physician organization,
1402 hospital system, or any other entity qualified under the laws of the commonwealth to perform or
1403 provide health care services. Physicians in contracting units of 24 physicians or fewer shall not
1404 be subject to this section.

1405 SECTION 112. Said chapter 118G is hereby further amended by striking out section 6A, as so
1406 appearing, and inserting in place thereof the following section:-

1407 Section 6A. (a) In fulfillment of its duties pursuant to clause (a) of the second paragraph of
1408 section 2, the division shall collect and analyze such data as it deems necessary in order to better
1409 protect the public's interest in monitoring the financial conditions of acute hospitals. Such
1410 information shall be analyzed on an industry-wide and hospital-specific basis and shall include,
1411 but not be limited to: (1) gross and net patient service revenues; (2) sources of hospital revenue,
1412 including revenue excluded from consideration in the establishment of hospital rates and charges
1413 pursuant to section 12; (3) private sector charges; (4) trends in inpatient and outpatient case mix,
1414 payor mix, hospital volume and length of stay; (5) total payroll as a percent of operating
1415 expenses, as well as the salary and benefits of the top 10 highest compensated employees,
1416 identified by position description and specialty; and (6) other relevant measures of financial
1417 health or distress.

1418 (b) The division shall publish annual reports and establish a continuing program of investigation
1419 and study of financial trends in the acute hospital industry, including an analysis of systemic
1420 instabilities or inefficiencies that contribute to financial distress in the acute hospital industry.
1421 Such reports shall include an identification and examination of hospitals that the division
1422 considers to be in financial distress, including any hospitals at risk of closing or discontinuing
1423 essential health services, as defined by the department of public health pursuant to section 51G
1424 of chapter 111, as a result of financial distress.

1425 (c) The division may modify uniform reporting requirements established pursuant to section 6
1426 and may require hospitals to report required information quarterly to effectuate the purposes of
1427 this section.

1428 SECTION 113. Section 7 of said chapter 118G , as so appearing, is hereby amended by
1429 inserting after the word " office", in line 1, the following words:— , in consultation with the
1430 division:.

1431 SECTION 114. Section 11 of said chapter 118G, as so appearing, is hereby amended by
1432 striking out, in line 45, the words "finance and policy" and inserting in place thereof the
1433 following words:— cost and quality.

1434 SECTION 115. Section 11 of said chapter 118G, as so appearing, is hereby amended by adding
1435 the following subsection:—

1436 (d) Notwithstanding any general or special law to the contrary, the executive office of
1437 health and human services shall require Medicaid, any carrier or other entity which contracts
1438 with the office of Medicaid to pay for or arrange for the purchase of health care services, the
1439 commonwealth care health insurance program established under chapter 118H, any carrier or
1440 other entity which contracts with the commonwealth care health insurance program to pay for or
1441 arrange for the purchase of health care services, the group insurance commission established
1442 under chapter 32A, and any other state sponsored or state managed plan providing health care
1443 benefits to reimburse any licensed hospital facility operating in the commonwealth that has been
1444 designated as a critical access hospital pursuant to U.S.C. 1395i-4, in an amount equal to at least
1445 101 per cent of allowable costs under each such program, as determined by utilizing the
1446 Medicare cost-based reimbursement methodology, for both inpatient and outpatient services
1447 provided to eligible patients of such facility.

1448 SECTION 116. Section 18B of said chapter 118G is hereby repealed.

1449 SECTION 117. Section 24 of said chapter 118G, as appearing in the 2010 Official Edition, is
1450 hereby amended by striking out, in line 7, the words “department of public health” and inserting
1451 in place thereof the following words:— division.

1452 SECTION 118. Section 34 of said chapter 118G, as so appearing, is hereby amended by
1453 striking out, in line 29, the words “finance and policy” and inserting in place thereof the
1454 following words:— cost and quality.

1455 SECTION 119. Section 35 of said chapter 118G, as so appearing, is hereby amended by striking
1456 out, in line 76, the words “finance and policy” and inserting in place thereof the following
1457 words:— cost and quality.

1458 SECTION 120. Section 40 of chapter 118G of the General Laws is hereby repealed.

1459 SECTION 121. Said chapter 118G is hereby further amended by adding the following 26
1460 sections:—

1461 Section 42. The division shall:

1462 (a) promote the reform of the health care delivery and payment system by state and private
1463 entities in the commonwealth;

1464 (b) encourage the establishment of alternative payment methodologies, ACOs and patient
1465 centered medical homes and to ensure consistency and efficacy in the establishment and use of
1466 quality measures throughout the commonwealth to promote patient-centered, timely, safe, high
1467 quality care for individuals in the commonwealth;

1468 (c) issue administrative bulletins and various other forms of official guidance that are necessary
1469 to effectuate the purposes of this chapter;

1470 (d) waive any of its requirements to permit and support innovative demonstrations or pilot
1471 programs; provided that such waivers may only be renewed if material savings or improvements
1472 in the delivery and quality of care can be documented, to the satisfaction of the division; and

1473 (e) establish safeguards against underutilization of innovative technologies and services,
1474 although they may represent a higher cost than the use of current therapies.

1475 (d) waive any of its requirements to permit and support innovative demonstrations or pilot
1476 programs; provided that such waivers may only be renewed if material savings or improvements
1477 in the delivery and quality of care can be documented, to the satisfaction of the division.

1478 Section 43. (a) The group insurance commission, the commonwealth health insurance connector
1479 authority, the office of Medicaid and any other state funded insurance program shall implement
1480 alternative payment methodologies for their respective covered lives and programs thereunder.

1481 (b) The executive office of health and human services shall seek a federal waiver of statutory
1482 provisions necessary to permit Medicare to participate in such alternative payment
1483 methodologies and use integrated care organizations, ACOs, and patient cenetered medical
1484 homes. Upon obtaining federal approval for Medicare participation, such participation shall be
1485 commenced and continued and the executive office shall seek extensions or additional approvals,
1486 as necessary. If federal approval cannot be obtained, or is revoked, then the requirements of this
1487 chapter and chapter 118J shall be conformed to federal standards for accountable care, sharved
1488 savings, bundled payments, or alternative payment arrangements, to the greatest extent
1489 practicable.

1490 (c) Private health plans shall implement alternative payment methodologies. Private health plans
1491 may seek a waiver from the division in order to use a different innovative system; provided,

1492 however, that the health plan seeking the waiver must demonstrate to the satisfaction of the
1493 division that any such system will provide the same level of incentives, risk sharing and cost-
1494 savings as the alternative payment methodologies defined in regulations of the division.

1495 (d) Any alternative payment methodology shall include a risk adjustment based on health status.
1496 The division shall create standards for the calculation of risk adjustments and update those
1497 standards on an annual basis; provided that such calculations as affect pediatric patients shall
1498 take into account the diagnoses and care needs of children. In establishing risk adjustment
1499 standards, the division may take into account functional status, socioeconomic or cultural factors.

1500

1501 Section 44. Payers who have not implemented compliant alternative payment methodologies by
1502 the date required in section 43, and who have not obtained a waiver under the provisions of
1503 subsection (c) of section 43, shall be subject to a penalty of $1 per member per month for the
1504 period of time during which such payer is not in compliance. The division shall assess and
1505 collect the penalties as provided in this section.

1506 Section 45. (a) By January 1, 2014, the division, in consultation with the office of Medicaid,
1507 shall develop and implement standards of certification for patient-centered medical homes. In
1508 developing these standards, the division shall consider existing standards by the National
1509 Committee for Quality Assurance or other independent accrediting and medical home
1510 organizations. The standards developed by the division shall include, but not limited to, the
1511 following criteria:

1512 (1) enhance access to routine care, urgent care and clinical advice though means such as
1513 implementing shared appointments, open scheduling and after-hours care;

1514 (2) enable and encourage utilization of a range of qualified health care professionals, including
1515 dedicated care coordinators, which may include, but not be limited to, nurse practitioners,
1516 physician assistants and social workers, in a manner that enables providers to practice to the
1517 fullest extent of their license;

1518 (3) encourage the use ofevidence based healthcare based on the most recently published peer
1519 reviewed literature, professional consensus, or best practices, shared decision-making aids that
1520 provide patients with information about treatment options and their associated benefits, risks,
1521 costs, and comparative outcomes, and other clinical decision support tools, including, but not
1522 limited to, decision aids on long-term care and supports and palliative care;

1523 (4) Ensure that patient-centered medical homes develop and maintain appropriate comprehensive
1524 care plans for their patients with complex or chronic conditions, including group visits, chronic
1525 disease self-management programs and an assessment of health risks and chronic conditions.;
1526

1527 (5) Promote the integration of mental health and behavioral health services with primary care
1528 services including, but not limited to, the establishment of a behavioral health medical home;
1529 recovery coaching and peer support, and services provided by peer support workers, certified
1530 peer specialists and licensed alcohol and drug counselors; and
1531

1532 (6) Improve access to health care services and quality of care for vulnerable populations
1533 including, but not limited to, children, the elderly, low-income individuals, individuals with
1534 disabilities, individuals with chronic illnesses and racial and ethnic minorities, including
1535 demonstrating an ability to provide culturally and linguistically appropriate care, patient
1536 education and outreach provided by community health workers.

1537 In developing these standards, the division shall consult with national and local organizations
1538 working on medical home models, relevant state agencies, health plans, physicians, nurse
1539 practitioners, behavioral health providers, hospitals, social workers, other health care providers
1540 and consumers. Furthermore, the division shall consult with the department of public health to
1541 maximize opportunities for administrative simplification and regulatory consistency.

1542 (b) Nothing in this section should be construed as prohibiting a primary care provider, behavioral
1543 health provider, or specialty care provider from being certified as a patient-centered medical
1544 home, provided that such providers meet the standards set by the division in accordance with this
1545 section or are recognized by the National Committee for Quality Assurance as a patient-centered
1546 medical home.

1547 (c) Certification as a patient-centered medical home is voluntary. Primary care providers,
1548 behavioral health providers, and specialty care providers certified by the division as a patient-
1549 centered medical home shall renew their certification on a periodic basis as determined by the
1550 division.

1551 (d) A primary care provider or specialty care provider certified as a patient-centered medical
1552 home shall have the ability to assess and provide or arrange for, and coordinate care with, mental
1553 health and substance abuse services, to the extent determined by the division. A behavioral
1554 health provider or specialty care provider certified as a patient-centered medical home shall have
1555 the ability to assess and provide or arrange for, and coordinate care with, primary care services,
1556 to the extent determined by the division.

1557 (e) By July 1, 2014, the division, in consultation with the office of Medicaid, shall establish a
1558 patient-centered medical home training for patient-centered medical homes to learn the core

1559 competencies of the patient-centered medical home model. The division may require
1560 participation in such training as a condition of certification.

1561 (f) For continued certification by the division under this section, the division may establish and
1562 monitor specific quality standards. Such quality standards shall be developed with reference to
1563 the standard quality measure set established by section 65 of chapter 118G.

1564 (g) In providing after-hours care, a patient-centered medical home may enter into a cooperative
1565 agreement with another medical home, primary care practice, limited service clinic, as defined
1566 by the department of public health, Medicare-certified home health agency for those patients that
1567 receive home-health services, or urgent care center to provide after-hours care for their patients.
1568 (h) The division shall develop a standard payment system for patient-centered medical homes
1569 certified under this section or recognized by the National Committee for Quality Assurance as a
1570 patient-centered medical home. In developing the standard payment system, the division shall
1571 consider, but not be limited to, per-patient payments, payment levels based on care-complexity,
1572 and payments for care coordination, clinical management, quality performance and shared
1573 savings. Development of the standard patient-centered medical home payment system shall be
1574 completed by January 1, 2014.

1575 (i) Payers shall make payments to patient-centered medical homes pursuant to the standard
1576 patient-centered medical home payment system established under subsection (h) for network
1577 providers certified as patient-centered medical homes under this section or recognized by the
1578 National Committee for Quality Assurance as a patient-centered medical home, or equivalent, as
1579 approved by the division. Medical home payments shall be in addition to any other payments,
1580 such as fee-for-service, global, and bundled payments. Subject to the other provisions of this

1581 legislation, final patient-centered medical home payment amounts shall be determined through
1582 contracts between payors and providers.

1583 (j) The division shall develop and distribute a directory of key existing referral systems and
1584 resources that can assist patients in obtaining housing, food, transportation, child care, elder
1585 services, long-term care services, peer services, and other community-based services. This
1586 directory shall be made available to patient-centered medical homes in order to connect patients
1587 to services in their community.

1588 (k) Nothing in this section shall preclude the continuation of existing patient-centered medical
1589 home or medical home programs currently operating or under development.

1590 Section 46. (a) The division shall calculate a statewide per capita medical spend benchmark by
1591 July 1. The benchmark shall be calculated by multiplying: (1) the statewide per capita medical
1592 spend benchmark of the prior year; and (2) the modified potential gross state product growth
1593 rate, as determined in subsection (b). For the initial statewide per capita medical spend
1594 benchmark in 2012, the division shall calculate the medical spend for 2011 and multiply that
1595 number by the modified potential gross state product growth rate for calendar year 2012. The
1596 statewide medical spend benchmark shall not be used by any party in any other setting, including
1597 but not limited to any proceeding arising out of the review by the division of insurance of any
1598 carrier’s insured rates, which are and shall be subject to disapproval if excessive, discriminatory,
1599 or unreasonable in relation to the benefits provided.

1600 (b) (1) As part of the governor's annual budget submission, the secretary for administration and
1601 finance shall publish the projected potential gross state product growth rate for the following

1602 calendar year beginning on January 1. Notwithstanding this subsection, for calendar years 2012
1603 and 2013 the projected potential gross state product growth rate shall be 3.6 per cent.

1604 (2) The division shall calculate the modified potential gross state product growth rate by taking
1605 the rate as defined by the secretary under paragraph (1) and making the following adjustments:
1606 (A) Calendar Years 2012 – 2015: no modification;
1607 (B) Calendar Years 2016 – 2026: minus 0.5 per cent; and
1608 (C) Calendar Years 2027 and beyond: plus 1 per cent.
1609 (c) The division shall calculate a regional per capita medical spend benchmark in a fashion
1610 similar to subsection (a) for each region. The division shall divide the commonwealth into 3
1611 geographic regions. The division may adjust the regions once every 5 years to account for any
1612 changes in medical operations that significantly impact the regions.
1613 Section 47. (a) As used in this section, the following word shall, unless the context clearly
1614 requires otherwise, have the following meaning:-

1615 "Health care entity", a clinic, hospital, ambulatory surgical center, physician organization,
1616 accountable care organization, or payer; provided, however, that physician contracting units of
1617 24 physicians or less or less shall be excluded from this definition.

1618 (b) Within 180 days of the end of each calendar year, the division shall conduct a review of the
1619 medical spend in each of the 3 geographic regions established under section 46; provided,
1620 however, that the division shall have 300 days for its initial review.

1621 (c) If the division determines that a regional per capita medical spend benchmark, as established
1622 under section 46, was met in a geographic region, then the division shall take no action on any
1623 health care entity within that region.

1624 (d) If the division determines that a region exceeded its regional per capita medical spend
1625 benchmark for the year, the division shall determine if the excess growth was caused in whole or
1626 in part by circumstances beyond the control of health care entities within such region. When
1627 reviewing the circumstances beyond the control of health care entities, the division may review
1628 items such as (1) age and other health status adjusted factors, (2) other cost inputs such as
1629 pharmaceutical expenses and medical device expenses, and (3) the region's ability to meet the
1630 benchmark in previous years. The division shall take no action if it determines that the excess
1631 growth was beyond the control of such health care entities.

1632 (e) If the division determines, under the analysis established under subsection (d), that excessive
1633 growth was not beyond the control of such health care entities, then the division shall analyze the
1634 cost growth of individual health care entities located within such region to identify any health
1635 care entity that exceeded the modified potential gross state product growth rate for that year.
1636 Based on the results of such analysis, beginning in calendar year 2016, the division may take
1637 actions as established under section 48.

1638 (f) The division shall provide notice to all health care entities within any geographic region that
1639 exceeds the regional per capita medical spend benchmark for a given year that said benchmark
1640 has been exceeded. Such notice shall state that the division may analyze the cost growth of
1641 individual health care entities located within such region and, beginning in calendar year 2016
1642 may require certain actions, as established in section 48, from health care entities that are
1643 determined to have exceeded the modified potential gross state product growth rate.

1644 (g) The division may submit a recommendation for proposed legislation to the joint committee
1645 on health care financing if the division determines that modified potential gross state product

1646 growth rate or actions under section 48 should be modified, or believes that further legislative
1647 authority is needed to achieve the health care quality and spending sustainability objectives of
1648 this act.

1649 Section 47A. The division shall provide a copy of any notices, issued pursuant to section 47, to
1650 the attorney general, who may obtain information submitted to or considered by the division in
1651 its review of cost growth for individual health care entities under section 47 as well as
1652 information related to any performance improvement plan required in accordance with section
1653 48.

1654 Section 48. (a) As used in this section, the following word shall have the following meaning:

1655 "Health care entity", a clinic, hospital, ambulatory surgical center, physician organization,
1656 accountable care organization, or payer; however provided that physician contracting units of 24
1657 physicians or less shall be excluded from this definition.

1658 Based on the analysis conducted under subsection (e) of section 47, the division may require any
1659 health care entity that exceeded the modified potential gross state product growth rate established
1660 under 46 to file a performance improvement plan with the division. The division shall provide
1661 written notice to such health care entity that they are required to file a performance improvement
1662 plan.

1663 (b) Said health care entity may file an application with the division to waive or extend the
1664 requirement to file a performance improvement plan.

1665 (c) The health care entity may file any documentation or supporting evidence with the division to
1666 support the health care entity's application to waive or extend the requirement to file a

1667 performance improvement plan. The division shall require the health care entity to submit any
1668 other relevant information it deems necessary in considering the waiver or extension application.

1669 (d) The division may waive or delay the requirement for a health care entity to file a performance
1670 improvement plan in response to a waiver or extension request filed under subsection (b) in light
1671 of all information received from the health care entity, based on a consideration of the following
1672 factors::

1673 (1) the costs, price and utilization trends of the health care entity over time, and
1674 any demonstrated improvement to reduce spending that exceeds the modified potential gross
1675 state product growth rate;

1676 (2) any ongoing strategies or investments that the health care entity is
1677 implementing to improve future long-term efficiency and reduce cost growth;

1678 (3) whether the factors that led to increased costs for the health care entity can
1679 reasonably be considered to be unanticipated and outside of the control of the entity;

1680 (4) the overall financial condition of the health care entity;

1681 (5) the proportionate impact of the health care entity's costs on the growth in
1682 medical spend within its region; and

1683 (6) any other factors the division considers relevant.

1684 (e) If the division declines to waive or extend the requirement for the health care entity to file a
1685 performance improvement plan, the division shall provide written notice to the health care entity
1686 that its application for a waiver or extension was denied and the health care entity shall file a
1687 performance improvement plan.

1688 (f) A health care entity shall file a performance improvement plan: (1) within 45 days of receipt
1689 of a notice under subsection (b); (2) if the health care entity has requested a waiver or extension,
1690 within 45 days of receipt of a notice that such waiver or extension has been denied; or (3) if the
1691 health care entity is granted an extension, on the date given on such extension. The performance
1692 improvement plan shall be generated by the health care entity and shall identify the causes of the
1693 entity's cost growth and shall include, but not be limited to, specific strategies, adjustments and
1694 action steps the entity proposes to implement to improve cost performance. The proposed
1695 performance improvement plan shall include specific identifiable and measurable expected
1696 outcomes and a timetable for implementation. The timetable for a performance improvement
1697 plan shall not exceed 18 months.

1698 (g) The division shall approve any performance improvement plan that it determines is
1699 reasonably likely to address the underlying cause of the entity's cost growth and has a reasonable
1700 expectation for successful implementation.

1701 (h) If the board determines that the performance improvement plan is unacceptable or
1702 incomplete, the division may provide consultation on the criteria that have not been met and may
1703 allow an additional time period, up to 30 calendar days, for resubmission; provided, however,
1704 that all aspects of the performance improvement plan shall be proposed by the health care entity
1705 and the division shall not require specific elements for approval.

1706 (i) Upon approval of the proposed performance improvement plan, the division shall notify the
1707 health care entity to begin immediate implementation of the performance improvement plan.
1708 Public notice shall be provided by the division on its website, identifying that the health care
1709 entity is implementing a performance improvement plan. All health care entities implementing

1710 an approved performance improvement plan shall be subject to additional reporting requirements
1711 and compliance monitoring, as determined by the division. The division shall provide assistance
1712 to the health care entity in the successful implementation of the performance improvement plan.

1713 (j) All health care entities shall, in good faith, work to implement the performance improvement
1714 plan. At any point during the implementation of the performance improvement plan the health
1715 care entity may file amendments to the performance improvement plan, subject to approval of
1716 the division.

1717 (k) At the conclusion of the timetable established in the performance improvement plan, the
1718 health care entity shall report to the division regarding the outcome of the performance
1719 improvement plan.

1720 (l) Upon the successful completion of the performance improvement plan, the identity of the
1721 health care entity shall be removed from the division's website.

1722 (m) Should the health care entity fail to successfully complete the performance improvement
1723 plan, the division may require the parties to resubmit a new plan consistent with this section. If
1724 the Division determines that the health care entity has not implemented the performance
1725 improvement plan to their satisfaction then they shall submit a recommendation for proposed
1726 legislation to the joint committee on health care financing if the division determines that further
1727 legislative authority is needed to achieve the health care quality and spending sustainability
1728 objectives of this act.(n) The division shall promulgate regulations necessary to implement this
1729 section; provided, however, that notice of any proposed regulations shall be filed with the joint
1730 committee on state administration and regulatory oversight and the joint committee on health
1731 care financing at least 180 days before adoption.

1732 Section 49. (a) Every provider may be subject to market impact review by the division;
1733 provided, however, that contracting units of 24 physicians of less shall not be subject to such
1734 review. The division shall establish, by regulation, rules for conducting market impact reviews.
1735 Such rules shall define primary service areas and dispersed service areas based on the geographic
1736 capacity of major service categories. The division shall conduct a market impact review for a
1737 provider when the division determines that market impact review is in the public interest. The
1738 division shall conduct a market impact review for any provider whose market concentration in
1739 primary or dispersed service areas exceeds the antitrust safety zone as set forth in Federal Trade
1740 Commission and Department of Justice Antitrust Division in the final policy statement of
1741 antitrust enforcement policy regarding ACOs participating in the Medicare shared savings
1742 program, 42 CFR 425. The division shall initiate a market impact review by sending such
1743 provider a notice of a market impact review which shall detail the particular factors that it seeks
1744 to examine through the review.

1745 (b) A market impact review may examine factors including, but not limited to: (1) the provider's
1746 size and market share by major service category within its primary service areas and dispersed
1747 service areas; (2) provider price, including its relative prices filed with the division of insurance
1748 pursuant to chapter 176S; (3) the provider's impact on competing options for the delivery of
1749 health care services within its primary service areas and dispersed service areas; including if not
1750 applicable , the impact on existing service providers of a provider organization's expansion,
1751 affiliation, merger or acquisition, to enter a primary or dispersed service area in which it did not
1752 previously operate; (4) the methods used by the organization to attract patient volume and to
1753 recruit or acquire health care professionals or facilities; (5) the role of the provider in serving at-
1754 risk, underserved and government payer patient populations within its primary service areas and

1755 dispersed service areas; (6) the financial solvency of the provider; and (7) consumer concerns,
1756 including but not limited to complaints or other allegations that the provider has engaged in any
1757 unfair method of competition or any unfair or deceptive act or practice.

1758 (c) The department of public health shall submit information to the division regarding any
1759 proposed projects, mergers or acquisitions that will result in a substantial capital expenditure or
1760 substantial change in services under determination of need with respect to a provider.

1761 (d) If, after completing a market impact review, the division determines that a substantial capital
1762 expenditure or substantial change in services has resulted or would result in any unfair method of
1763 competition, any unfair or deceptive act or practice, as defined in chapter 93A, or determines that
1764 a proposed project, merger or acquisition will result in a material change under determination of
1765 need that would result in any unfair method of competition, or any unfair or deceptive act or
1766 practice, the division shall refer its findings, together with any supporting documents, data or
1767 information to the attorney general for further review and action.

1768 Section 50. (a) The division shall publish reports on the cost, quantity and quality of health care
1769 services delivered in the commonwealth. A copy of such report shall be submitted to the chairs
1770 of the house and senate committees on ways and means and joint committee on health care
1771 financing. Such reports shall include, but not be limited to:

1772 (1) an annual report on the outcomes of payment reform which shall include, but not be limited
1773 to the achievement of benchmarks for the reduction of health care costs and improvement in
1774 quality, analyzed by region of the commonwealth, the proportion of health care expenditures
1775 reimbursed under fee-for-service and alternative payment methodologies, and trends in medical
1776 spending, including, but not limited to, cost growth trends for fee-for-service rates and

1777 alternative payment methodologies, cost growth trends for care provided within and outside of
1778 ACOs and patient-centered medical homes, and cost growth trends by provider sector, including,
1779 but not limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical
1780 devices and durable medical equipment;

1781 (2) a biannual report on ACOs in the commonwealth which shall include, but not be limited to:
1782 the number and geographic distribution of ACOs; the number, proportion and type of providers
1783 affiliating with an ACO; the number and proportion of patients receiving care in an ACO; the
1784 number and characteristics of patients within ACOs with complex or chronic conditions; the
1785 quality performance of ACOs; the impact of ACOs on health disparities; and ACO payment
1786 arrangements.; and

1787 (3) a biannual report on patient-centered medical homes in the commonwealth which shall
1788 include, but not be limited to: (i) the number and geographic distribution of patient-centered
1789 medical homes; (ii) the number and proportion of patient-centered medical homes which are
1790 based in primary care practices, specialty care practices, and behavioral health care practices;
1791 (iii) the number and proportion of patients receiving care in patient-centered medical homes; (iv)
1792 the number and characteristics of patients within patient-centered medical homes with complex
1793 or chronic conditions; (v) the quality performance of patient-centered medical homes; (vi) the
1794 impact of patient-centered medical homes on health disparities; and (vii) patient-centered
1795 medical home payment arrangements.

1796 (b) The division shall annually report on or commission an annual independent survey of
1797 patient and caregiver experience and satisfaction with the health care system, taking into account
1798 care provided by primary care providers, hospitals, ACOs and other care networks. The report or

1799 survey shall also assess patients' perceptions on their access to services, including, but not
1800 limited to, health care services, as defined in section 1 of chapter 118G of the General Laws,
1801 mental health and primary care, including, but not limited to, obstectrics and gynecology;
1802 patients' perceptions of the impact of health insurance premiums and out-of-pocket expenditures
1803 on access to care and affording other necessities; the experience of vulnerable populations such
1804 as the homeless, those with disabilities, women, the elderly and children; and differences in
1805 experience by racial, ethnic and socioeconomic background.

1806 Section 51. (a) To facilitate the sharing of health care data between payers, providers, employers
1807 and consumers, the division shall:—

1808 (1) establish procedures for payers to report to insureds their out-of-pocket costs, including, but
1809 not limited to, requiring payers to provide a toll-free number and website that enables consumers
1810 to request and obtain from a payer in real time the maximum estimated amount the insured will
1811 be responsible to pay for a proposed admission, procedure or service that is a medically
1812 necessary covered benefit, based on the information available to the carrier at the time the
1813 request is made, including any copayment, deductible, coinsurance or other out of pocket
1814 amount, for any health care benefits; a determination of which admissions, procedures or
1815 services must be included in the toll-free number and website; and disclosures to be made
1816 alerting consumers that these are estimated costs, and that the actual amount the insured will be
1817 responsible to pay for a proposed admission, procedure or service may vary.

1818 (2) establish procedures for the division to disclose to providers, on a timely basis, the
1819 contracted prices of individual health care services so as to aid in patient referrals and the

1820 management of alternative payment methodologies. Contracted prices shall be listed by provider
1821 and payer;

1822 (3) establish procedures for payers to disclose patient-level data including, but not limited to,
1823 health care service utilization, medical expenses, demographics, and where services are being
1824 provided, to all providers in their network, provided that data shall be limited to patients treated
1825 by that provider, so as to aid providers in managing the care of their own patient panel;

1826 (4) establish procedures for third-party administrators to disclose to self-insured group clients
1827 the prices and quality of services of in-network providers; and

1828 (5) establish procedures for health care providers, upon the request of a patient or prospective
1829 patient, to disclose the charges, and if available, the allowed amount, or where it is not possible
1830 to quote a specific amount in advance due to the health care provider's inability to predict the
1831 specific treatment or diagnostic code, the estimated charges or estimated allowed amount for a
1832 proposed admission, procedure or service.

1833 (b) The division shall ensure that all data collection, analysis and other submission requirements
1834 established under this section are implemented in a manner that promotes administrative
1835 simplification and avoids duplication.

1836 (c) The division shall ensure the timely reporting of information required under this section. The
1837 division may assess penalties against any reporting entity that fails to meet a reporting deadline.
1838 Said funds shall be deposited into the wellness and prevention trust fund, as established in
1839 section 75 of chapter 10.

1840 Section 52. The division shall coordinate among state agencies the streamlining and
1841 simplification of state health care data reporting requirements and make recommendations to the
1842 joint committee on health care financing for any necessary legislation to further such
1843 simplification.

1844 Section 53. (a) The division shall require ACOs to provide financial data on an annual basis
1845 before April 1. The division may require information related to ACOs, including, but not limited
1846 to: (1) annual receipts; (2) annual costs; (3) realized capital gains and losses; (4) accumulated
1847 surplus; (5) accumulated reserves; (6) administrative expenses; (7) marketing expenses; (8)
1848 charitable expenses; and (9) any other information deemed necessary by the division.

1849 (b) An ACO who fails to submit such statement before April 1 shall be assessed a late penalty
1850 not to exceed $100 per day. Amounts pursuant to this section shall be deposited to the Wellness
1851 and Prevention Trust Fund established under section 75 of chapter 10 of the General Laws . The
1852 division shall make public all of the information collected under this section. The division shall,
1853 from time to time, require ACOs to submit the underlying data used in their calculations for
1854 audit.

1855 The division may adopt rules to carry out this subsection and criteria for the standardized
1856 reporting and uniform allocation methodologies among ACOs. The division shall, before
1857 adopting regulations under this subsection, consult with other agencies of the commonwealth and
1858 the federal government and affected carriers to ensure that the reporting requirements imposed
1859 under the regulations are not duplicative.

1860 Section 54. (a) The division shall calculate a statewide median contracted price for a set of health
1861 care services provided by hospitals, physician organizations and free standing surgical centers.

1862 The division shall establish a uniform methodology to collect all necessary information to
1863 calculate such prices. The statewide median contracted price shall be calculated on an annual
1864 basis.

1865 (b) The division shall also calculate a provider-specific average contracted price relative to the
1866 statewide median contracted price for a comparable set of services, based on a weighting formula
1867 to be determined by the division. The division shall also calculate a provider-specific measure of
1868 the total units of service provided, based on a weighting formula to be determined by the
1869 division.

1870 (c) Any hospital, physician organization, and free standing surgical center shall be assessed a
1871 surcharge if their contracted average price exceeds 120 percent of the comparable statewide
1872 median contracted price.

1873 (d) The surcharge amount shall be equal to 10 per cent of the surplus amount. The surplus
1874 amount shall be equal to the units of comparable services provided multiplied by the difference
1875 between the provider-specific average contracted price and the statewide median contracted price
1876 for the comparable set of services. The division shall exempt units of service from the surcharge
1877 if (1) said service has limited or exclusive availability in the commonwealth, as determined by
1878 the division; or (2) the division determines that the quality of the service is reasonably related to
1879 the price.

1880 (e) The assessment shall be paid to the division on a quarterly basis. The funds from the
1881 assessment shall be placed in the distressed hospital trust fund, as established under section
1882 2GGGG of chapter 29.

1883 (f) Providers are prohibited from passing along the costs of this surcharge to consumers.

1884 (g) Failure to report or pay the division in a timely fashion shall result in an interest charge at an
1885 annual rate equal to the weekly average 1-year constant maturity Treasury yield plus 4 per cent,
1886 as published by the Board of Governors of the Federal Reserve System for the calendar week
1887 preceding the date of non-compliance.

1888 (h) The division shall promulgate all necessary regulations to implement this section.

1889 Section 55. (a) Third party administrators of self-funded plans shall implement alternative
1890 payment methods in accordance with this chapter and all other laws. With the input of expert
1891 advice, the division shall evaluate and take measures to address ERISA restrictions and
1892 recommend potential incentives for employers who participate in self-funded plans to participate
1893 in alternative payment methods.

1894 Section 56. (a) The division shall disseminate the data it collects under this section to consumers,
1895 health care providers and payers through: (1) a publicly-accessible consumer health information
1896 website; (2) reports on performance provided to health care providers; and (3) any other analysis
1897 and reporting the division deems appropriate.

1898 When collecting data, the division shall, to the extent possible, utilize existing public and private
1899 data sources and agency processes for data collection, analysis and technical assistance. The
1900 division may enter into an interagency service agreement with other state agencies for data
1901 collection analysis and technical assistance; provided any such interagency agreement with the
1902 Department of Revenue shall meet all applicable federal and state privacy and security
1903 requirements, including requirements imposed by the Health Insurance Portability and
1904 Accountability Act of 1996, P.L. 104-191, the American Recovery and Reinvestment Act of

1905 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R. §§160, 162, 164 and 170 and shall not
1906 cause patient payment to Department of Revenue through use of protected health information.

1907 The division may contract with an independent health care organization for data collection,
1908 analysis or technical assistance related to its duties; provided, however, that the organization has
1909 a history of demonstrating the skill and expertise necessary to: (1) collect, analyze and aggregate
1910 data related to quality and cost across the health care system; (2) identify quality improvement
1911 areas through data analysis; (3) work with Medicare, MassHealth, and other insurers' data; (4)
1912 collaborate in the design and implementation of quality improvement and clinical performance
1913 measures; (5) establish and maintain security measures necessary to maintain confidentiality and
1914 preserve the integrity of the data; and (6) identify and, when necessary, develop appropriate
1915 measures of quality and cost for public reporting of quality and cost information.

1916 Payers and health care providers shall submit data to the division or an independent health care
1917 organization with which the division has contracted, as required by the division's regulations.
1918 The division, through its rules and regulations, may determine what type of data may reasonably
1919 be required and the format in which it shall be provided.

1920 The division may request that third-party administrators submit data to the division or to an
1921 independent health care organization with which the division has contracted. The division,
1922 through its rules and regulations, may determine the format in which the data shall be provided.
1923 The division shall publicly post a list of third-party administrators that refuse to submit requested
1924 data.

1925 If any payer or health care provider fails to submit required data to the division on a timely basis,
1926 the division shall provide written notice to the payer or health care provider. A payer or health

1927 care provider that fails, without just cause, to provide the required information within 2 weeks
1928 following receipt of the written notice may be required to pay a penalty of $1,000 for each week
1929 of delay; provided, however, that the maximum annual penalty under this section shall be
1930 $50,000.

1931 (b) The division, through its rules and regulations, shall provide access to data it collects
1932 pursuant to this section. Access to data shall include, but not be limited to, disclosing to
1933 providers, on a timely basis, the contracted prices of individual health care services so as to aid
1934 in patient referrals and the management of alternative payment methodologies. Contracted prices
1935 shall be listed by provider and payer. Access to data shall also include disclosing to health care
1936 consumers, on a timely basis and in an easily readable and understandable format, data on health
1937 care services they have personally received. The division shall provide data under conditions
1938 that: (1) protect patient privacy; (2) prevent collusion or anti-competitive conduct; and (3)
1939 prevent the release of data that could reasonably be expected to increase the cost of health care.
1940 The division may limit access to data based on its proposed use, the credentials of the requesting
1941 party, the type of data requested or other criteria required to make a determination regarding the
1942 appropriate release of the data. The division shall also limit the requesting party's use and release
1943 of any data to which that party has been given access by the division. The division shall maintain
1944 a database of health care claims submitted pursuant to this section for the purpose of conducting
1945 data analysis and preparing reports to assist in the formulation of health care policy and the
1946 provisions and purchase of health care services.

1947 Data collected by the division under this section shall not be a public record under clause
1948 Twenty-sixth of section 7 of chapter 4 or under chapter 66, except as specifically otherwise
1949 provided by the council.

1950 The division shall, through interagency service agreements, allow the use of its data by other
1951 state agencies for review and evaluation of mandated health benefit proposals as required by
1952 section 38C of chapter 3.

1953 (c) The division shall disseminate to health care providers their individualized de-identified data,
1954 including comparisons with other health care providers on the quality, cost and other data to be
1955 published on the consumer health information website.

1956 (d) The division shall coordinate and compile data on quality improvement programs conducted
1957 by state agencies and public and private health care organizations. The division shall consider
1958 programs designed to: (1) improve patient safety in all settings of care; (2) reduce preventable
1959 hospital readmissions; (3) prevent the occurrence of and improve the treatment and coordination
1960 of care for chronic diseases; and (4) reduce variations in care. The division shall make such
1961 information available on the division's consumer health information website. The division may
1962 recommend legislation or regulatory changes as needed to further implement quality
1963 improvement initiatives.

1964 Section 57. (a) The division shall establish and maintain a consumer health information website.
1965 The website shall contain information comparing the quality and cost of health care services and
1966 show how providers and payers are doing in relation to the statewide and regional benchmarks
1967 and growth goals, and may also contain general health care information as the division deems
1968 appropriate. The website shall be designed to assist consumers in making informed decisions
1969 regarding their medical care and informed choices among health care providers. Information
1970 shall be presented in a format that is understandable to the average consumer. The division shall
1971 publicize the availability of its website.

1972 (b) The website shall provide updated information on a regular basis, at least annually, and
1973 additional comparative quality and price information shall be published as determined by the
1974 division. To the extent possible, the website shall include: (1) comparative price information for
1975 the most common referral or prescribed services, as determined by the division, and shall be
1976 listed by facility, provider, provider group practice, ACO, or any other provider grouping, as
1977 determined by the division, provided that such information is categorized by payor; (2)
1978 comparative quality information, as determined by division, available by facility, provider,
1979 provider group practice, ACO or any other provider grouping, as determined by the division, for
1980 each such service for which comparative price information is provided; (3) general information
1981 related to each service for which comparative information is provided; (4) comparative quality
1982 information, as determined by the division, available by facility, provider, provider group
1983 practice or ACO that is not service-specific, including information related to patient safety and
1984 satisfaction; (5) data concerning healthcare-associated infections and serious reportable events
1985 reported under section 51H of chapter 111; (6) definitions of common health insurance and
1986 medical terms, including, but not limited to, those determined under sections 2715(g)(2) and (3)
1987 of the Public Service Act, so that consumers may compare health coverage and understand the
1988 terms of their coverage; (7) a list of health care provider types, including but not limited to
1989 primary care physicians, nurse practitioners and physician assistants, and what types of services
1990 they are authorized to perform in the commonwealth under state and federal scope of practice
1991 laws; (8) factors consumers should consider when choosing an insurance product or provider
1992 group, including, but not limited to, provider network, premium, cost-sharing, covered services,
1993 and tiering; (9) decision aids for patients to facilitate conversations with their health care
1994 providers on key health decisions, including but not limited to, decision aids on long-term care

1995 and supports and palliative care; and (10) descriptions of standard quality measures, as
1996 determined by the division.

1997 (c) The division shall develop and adopt, on an annual basis, a reporting plan specifying the
1998 quality and cost measures to be included on the consumer health information website and the
1999 security measures used to maintain confidentiality and preserve the integrity of the data. In
2000 developing the reporting plan, the division, to the extent possible, shall collaborate with other
2001 organizations or state or federal agencies that develop, collect and publicly report health care
2002 quality and cost measures and the division shall give priority to those measures that are already
2003 available in the public domain. As part of the reporting plan, the division shall determine for
2004 each service the comparative information to be included on the consumer health information
2005 website.

2006 (d) In designing the website, the division may conduct research regarding ease of use of the
2007 website by health care consumers, consult with organizations that represent health care
2008 consumers, and conduct focus groups that represent a cross section of health care consumers in
2009 the commonwealth, including low income consumers and consumers with limited literacy. The
2010 website shall comply with the Americans with Disabilities Act.

2011 Section 58. (a) There shall be in the division a health care workforce center to improve access to
2012 health care services. The center and the commissioner of labor and workforce development,
2013 shall: (1) coordinate the division's health care workforce activities with other state agencies and
2014 public and private entities involved in health care workforce training, recruitment and retention;
2015 (2) monitor trends in access to primary care providers, and nurse practitioners and physician
2016 assistants practicing as primary care providers, and other physician and nursing providers,

2017 through activities including (i) review of existing data and collection of new data as needed to
2018 assess the capacity of the health care workforce to serve patients, including patients with
2019 disabilities whose disabilities may include but are not limited to intellectual and developmental
2020 disabilities, including patient access and regional disparities in access to physicians, nurses or
2021 physician assistants and to examine physician, nursing and physician assistant satisfaction; (ii)
2022 review existing laws, regulations, policies, contracting or reimbursement practices, and other
2023 factors that influence recruitment and retention of physicians, nurses and physician assistants;
2024 (iii) making projections on the ability of the workforce to meet the needs of patients over time;
2025 (iv) identifying strategies currently being employed to address workforce needs, shortages,
2026 recruitment and retention; (v) studying the capacity of public and private medical, nursing and
2027 physician assistant schools in the commonwealth to expand the supply of primary care
2028 physicians and nurse practitioners and physician assistants practicing as primary care providers;
2029 (3) establish criteria to identify underserved areas in the commonwealth for administering the
2030 loan repayment program established under section 60 and for determining statewide target areas
2031 for health care provider placement based on the level of access; and (4) address health care
2032 workforce shortages through the following activities, including: (i) coordinating state and federal
2033 loan repayment and incentive programs for health care providers; (ii) providing assistance and
2034 support to communities, physician groups, community health centers and community hospitals in
2035 developing cost-effective and comprehensive recruitment initiatives; (iii) maximizing all sources
2036 of public and private funds for recruitment initiatives; (iv) designing pilot programs and making
2037 regulatory and legislative proposals to address workforce needs, shortages, recruitment and
2038 retention; (v) making short-term and long-term programmatic and policy recommendations to
2039 improve workforce performance, address identified workforce shortages and recruit and retain

2040 physicians, nurses and physician assistants; and (vi) administering the health care workforce trust
2041 fund as established under section 2FFFF of chapter 29.

2042 (b) The center shall maintain ongoing communication and coordination with the health
2043 disparities council, established by section 16O of chapter 6A.

2044 (c) The center shall annually submit a report, not later than March 1, to the Governor, the health
2045 disparities council, established by section 16O of chapter 6A; and the General Court, by filing
2046 the report with the clerk of the house of representatives, the clerk of the senate, the joint
2047 committee on labor and workforce development, the joint committee on health care financing,
2048 and the joint committee on public health. The report shall include: (1) data on patient access and
2049 regional disparities in access to physicians, by specialty and sub-specialty, and nurses and
2050 physician assistants; (2) data on factors influencing recruitment and retention of physicians,
2051 nurses and physician assistants; (3) short and long-term projections of physician, nurse and
2052 physician assistant supply and demand; (4) strategies being employed by the council or other
2053 entities to address workforce needs, shortages, recruitment and retention; (5) recommendations
2054 for designing, implementing and improving programs or policies to address workforce needs,
2055 shortages, recruitment and retention; and (6) proposals for statutory or regulatory changes to
2056 address workforce needs, shortages, recruitment and retention.

2057 Section 59. (a) There shall be a health care workforce loan repayment program, administered by
2058 the health care workforce center established by section 59. The program shall provide repayment
2059 assistance for medical or nursing school loans to participants who: (1) are graduates of medical
2060 physician assistant or nursing schools; (2) specialize in family health or medicine, internal
2061 medicine, pediatrics, psychiatry or obstetrics and gynecology; (3) demonstrate competency in

2062 health information technology at least equivalent to federal meaningful use standards as set forth
2063 in 45 C.F.R. Part 170, including use of electronic medical records, computerized physician order
2064 entry and e-prescribing; and (4) meet other eligibility criteria, including service requirements,
2065 established by the board. Each recipient shall be required to enter into a contract with the
2066 commonwealth which shall oblige the recipient to perform a term of service of no less than 2
2067 years in medically underserved areas, as determined by the center.

2068 (b) The center shall promulgate regulations for the administration and enforcement of this
2069 section which shall include penalties and repayment procedures if a participant fails to comply
2070 with the service contract.

2071 The center shall establish criteria to identify medically underserved areas within the
2072 commonwealth. These criteria shall consist of quantifiable measures, which may include the
2073 availability of primary care medical services within reasonable traveling distance, poverty levels
2074 and disparities in health care access or health outcomes.

2075 Section 60. (a) As used in this section, "primary care provider", shall mean a health care
2076 professional qualified to provide general medical care for common health care problems who: (1)
2077 supervises, coordinates, prescribes or otherwise provides or proposes health care services; (2)
2078 initiates referrals for specialist care; and (3) maintains continuity of care within the scope of
2079 practice.

2080 (b) Pursuant to regulations to be promulgated by the health care workforce center, there shall be
2081 established a primary care residency grant program for the purpose of financing the training of
2082 primary care providers at teaching community health centers. Eligible applicants shall include
2083 teaching community health centers accredited through affiliations with a commonwealth-funded

2084 medical school or licensed as part of a teaching hospital with a residency program in primary
2085 care or family medicine and teaching health centers that are the independently accredited
2086 sponsoring organization for the residency program and whose residents are employed by the
2087 health center.

2088 To receive funding, an applicant shall: (1) include a review of recent graduates of the community
2089 health center's residency program, including information regarding what type of practice said
2090 graduates are involved in 2 years following graduation from the residency program; and (2)
2091 achieve a threshold of at least 50 percent for the percentage of graduates practicing primary care
2092 within 2 years after graduation. Graduates practicing more than 50 percent inpatient care or
2093 more than 50 percent specialty care as listed in the American Medical Association Masterfile
2094 shall not qualify as graduates practicing primary care.

2095 Awardees of the primary care residency grant program shall maintain their teaching accreditation
2096 as either an independent teaching community health center or as a teaching community health
2097 center accredited through affiliation with a commonwealth-funded medical school or licensed as
2098 part of a teaching hospital.

2099 The health care workforce center shall determine through regulation grant amounts per full-time
2100 resident. Funds for such grants shall come from the Health Care Workforce Trust Fund
2101 established under section 2FFFF of chapter 29.

2102 Section 61. Pursuant to regulations to be promulgated by the health care workforce center, there
2103 shall be established a primary care workforce development and loan forgiveness grant program
2104 at community health centers, for the purpose of enhancing recruitment and retention of primary
2105 care physicians and other clinicians at community health centers throughout the commonwealth.

2106 Such grant program shall be administered by the Massachusetts League of Community Health
2107 Centers, hereinafter referred to as the League, in consultation with the director of the health care
2108 workforce center and relevant member agencies. Funds may be matched by other public and
2109 private funds. The League shall work with said director and said agencies to maximize all
2110 sources of public and private funds.

2111 Section 62. (a) There is hereby established within the division an office of patient protection. The
2112 office shall:—

2113 (1) have the authority to administer and enforce the standards and procedures established by
2114 sections 13, 14, 15 and 16 of chapter 176O. The division shall promulgate such regulations to
2115 enforce this section. Such regulations shall protect the confidentiality of any information about a
2116 carrier or utilization review organization, as defined in said chapter 176O, which, in the opinion
2117 of the office, and in consultation with the division of insurance, is proprietary in nature and is not
2118 in the public interest to disclose. Utilization review criteria, medical necessity criteria and
2119 protocols must be made available to the public at no charge regardless of proprietary claims. The
2120 regulations authorized by this section shall be consistent with, and not duplicate or overlap with,
2121 regulations promulgated by the bureau of managed care established in the division of insurance
2122 pursuant to said chapter 176O;

2123 (2) make managed care information collected by the office readily accessible to consumers on
2124 the division of health care cost and quality website. The information shall, at a minimum, include
2125 (i) the health plan report card developed pursuant to section 24 of chapter 118G, (ii) a chart,
2126 prepared by the office, comparing the information obtained on premium revenue expended for
2127 health care services as provided pursuant to subsection (3) of paragraph (b) of section 7 of

2128 chapter 176O, for the most recent year for which information is available, and (iii) data collected
2129 pursuant to paragraph (c);

2130 (3) assist consumers with questions or concerns relating to managed care, including, but not
2131 limited to, exercising the grievance and appeals rights established by sections 13 and 14 of said
2132 chapter 176O;

2133 (4) monitor quality-related health insurance plan information relating to managed care practices;

2134 (5) regulate the establishment and functions of review panels established by section 14 of chapter
2135 176O;

2136 (6) periodically advise the division, the commissioner of insurance, the managed care oversight
2137 board, established by section 16D of chapter 6A, the joint committee on health care financing
2138 and the joint committee on financial services on actions, including legislation, which may
2139 improve the quality of managed care health insurance plans;

2140 (7) administer and grant enrollment waivers under paragraph (4) of subsection (a) of section 4 of
2141 chapter 176J; provided, however, that the office of patient protection may grant a waiver to an
2142 eligible individual who certifies, under penalty of perjury, that such individual did not
2143 intentionally forego enrollment into coverage for which the individual is eligible and that is at
2144 least actuarially equivalent to minimum creditable coverage; provided further, that the office
2145 shall establish, by regulation, standards and procedures for enrollment waivers; and

2146 (8) establish, by regulation, procedures and rules relating to appeals by consumers aggrieved by
2147 restrictions on patient choice, denials of services or quality of care resulting from any final action

2148 of an ACO, and to conduct hearings and issue rulings on appeals brought by ACO consumers
2149 that are not otherwise properly heard through the consumer's payer or provider.

2150 (b) The division shall establish an external review system for the review of grievances
2151 submitted by or on behalf of insureds of carriers pursuant to section 14 of chapter 176O. The
2152 division shall establish an external review process for the review of grievances submitted by or
2153 on behalf of ACO patients and shall specify the maximum amount of time for the completion of
2154 a determination and review after a grievance is submitted. The division shall establish expedited
2155 review procedures applicable to emergency situations, as defined by regulation promulgated by
2156 the division.

2157 (c) Each entity that compiles the health plan employer data and information set, so-called, for
2158 the National Committee on Quality Assurance, or collects other information deemed by the
2159 entity as similar or equivalent thereto, shall, upon submitting said data and information sent to
2160 the division of health care cost and quality pursuant to section 24 of chapter 118G, concurrently
2161 submit to the office of patient protection a copy thereof, excluding, at the entity's option,
2162 proprietary financial data.

2163 Section 63. The division shall keep an accurate account of all its activities and of all its receipts
2164 and expenditures and shall annually make a report thereof as of the end of its fiscal year to its
2165 board, to the governor, to the general court, and to the state auditor, such reports to be in a form
2166 prescribed by the board, with the written approval of the auditor. The auditor may investigate the
2167 affairs of the division, may severally examine the properties and records of the division, and may
2168 prescribe methods of accounting and of rendering of periodic reports in relation to projects
2169 undertaken by the division. The division shall be subject to biennial audit by the state auditor.

2170 Section 64. The division shall develop the uniform reporting of a standard set of health care
2171 quality measures for each health care provider facility, medical group, or provider group in the
2172 commonwealth hereinafter referred to as the "standard quality measure set."

2173 The division shall convene a statewide advisory committee which shall recommend to the
2174 division a standard quality measure set. The statewide advisory committee shall consist of the
2175 executive director of the division or designee, who shall serve as the chair; the executive director
2176 of the group insurance commission or designee, the Medicaid director or designee; and 7
2177 representatives of organizations to be appointed by the governor including at least 1
2178 representative from an acute care hospital or hospital association, 1 representative from a
2179 provider group or medical association or provider association, 1 representative from a medical
2180 group, 1 representative from a private health plan, 1 representative from the Massachusetts
2181 Association of Health Plans, 1 representative from an employer association and 1 representative
2182 from a health care consumer group.

2183 In developing its recommendation of the standard quality measure set, the advisory committee
2184 shall, after consulting with state and national organizations that monitor and develop quality and
2185 safety measures, select from existing quality measures and shall not select quality measures that
2186 are still in development or develop its own quality measures. The committee shall annually
2187 recommend to the division any updates to the standard quality measure set on or before
2188 November 1. The committee may solicit for consideration and recommend other nationally
2189 recognized quality measures, including, but not limited to, recommendations from medical or
2190 provider specialty groups as to appropriate quality measures for that group's specialty. At a
2191 minimum, the standard quality measure set shall consist of the following quality measures: (i)
2192 the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial

2193 infarction, congestive heart failure, pneumonia and surgical infection prevention; (ii) the
2194 Hospital Consumer Assessment of Healthcare Providers and Systems survey; (iii) the Healthcare
2195 Effectiveness Data and Information Set reported as individual measures and as a weighted
2196 aggregate of the individual measures by medical or provider group; and (iv) the Ambulatory
2197 Care Experiences Survey. The Standard Quality Measure Set shall include outcome measures.
2198 The Committee shall review additional appropriate outcome measures as they are developed.

2199 Section 65. (a) As used in this section, the following words the following words shall, unless the
2200 context clearly requires otherwise, have the following meanings:-

2201 “Administrative surcharge payer”, an individual or entity that pays for or arranges for the
2202 purchase of health care services provided by acute hospitals, ambulatory surgical centers, ACOs
2203 or physician organizations, as defined in this chapter; provided, however, that the term
2204 “administrative surcharge payer” shall include a managed care organization; and provided,
2205 further, that “administrative surcharge payer” shall not include Title XVIII and Title XIX
2206 programs and their beneficiaries or recipients, other governmental programs of public assistance
2207 and their beneficiaries or recipients and the workers’ compensation program established under
2208 chapter 152.

2209 "Net amount", the amount established for the estimated annual expenses of the division of health
2210 care cost and quality, established by section 2, and the health safety net office, established by
2211 section 35. This amount shall be equal to the amount appropriated by the general court for the
2212 expenses of the division of health care cost and quality and the health safety net office minus
2213 amounts collected from (1) filing fees; (2) fees and charges generated by the division’s
2214 publication or dissemination of reports and information; and (3) federal matching revenues

2215 received for these expenses or received retroactively for expenses of predecessor agencies.
2216 Estimated and actual expenses of the division and the office shall include an amount equal to the
2217 cost of fringe benefits, as established by the division of administration pursuant to section 6B of
2218 chapter 29.

2219 "Payments subject to administrative surcharge", all amounts paid, directly or indirectly, by
2220 administrative surcharge payers to acute hospitals, ambulatory surgical centers, ACOs and
2221 physician organizations for health services, provided, however, that "payments subject to
2222 administrative surcharge" shall not include, (i) payments, settlements and judgments arising out
2223 of third party liability claims for bodily injury which are paid under the terms of property or
2224 casualty insurance policies; (ii) payments made on behalf of Medicaid recipients, Medicare
2225 beneficiaries or persons enrolled in policies issued under chapter 176K or similar policies issued
2226 on a group basis, provided further, that "payments subject to administrative surcharge" shall
2227 include payments made by a managed care organization on behalf of: (i) Medicaid recipients
2228 under age 65; and (ii) enrollees in the commonwealth care health insurance program, and
2229 provided further, that "payments subject to administrative surcharge" may exclude amounts
2230 established under regulations promulgated by the division for which the costs and efficiency of
2231 billing an administrative surcharge payer or enforcing collection of the surcharge from an
2232 administrative surcharge payer would not be cost effective.

2233 (b) Acute hospitals, as defined in section 34, ambulatory surgical centers, as defined in section
2234 34, ACOs, as defined in section 1, and physician organizations, as defined in section 53H of
2235 chapter 111, shall pay for the estimated expenses of the division and health safety net office.
2236 The amount to be paid for such expenses shall be equal to the net amount, as defined in
2237 subsection (g). Acute hospitals, ambulatory surgical centers, ACOs and physician organizations

2238 shall assess an administrative surcharge on all payments subject to administrative surcharge as
2239 defined in subsection (g). The administrative surcharge shall be distinct from any other amount
2240 paid by an administrative surcharge payer, as defined in subsection (g), for the services of an
2241 acute hospital, ambulatory surgical center, ACO or physician organization and shall be in
2242 addition to the surcharge imposed under section 38. The administrative surcharge amount shall
2243 equal the product of (i) the administrative surcharge percentage and (ii) amounts paid for these
2244 services by an administrative surcharge payer. The division shall calculate the administrative
2245 surcharge percentage by dividing the net amount, as defined in this section, by the projected
2246 annual aggregate payments subject to the administrative surcharge, excluding projected annual
2247 aggregate payments based on payments made by managed care organizations. The division shall
2248 subsequently adjust the administrative surcharge percentage for any variation in the net amount.
2249 The division shall determine the administrative surcharge percentage before the start of each
2250 fiscal year and may recalculate the surcharge percentage before April 1 of each fiscal year if the
2251 division projects that the initial administrative surcharge percentage established the previous
2252 October will produce less or more than the net amount in administrative surcharge payments,
2253 excluding payments made by managed care organizations, as defined in section 34. Before each
2254 succeeding October 1, the division shall recalculate the administrative surcharge percentage
2255 incorporating any adjustments from earlier years. In each calculation or recalculation of the
2256 administrative surcharge percentage, the division shall use the best data available as determined
2257 by the division and may consider the effect on projected administrative surcharge payments of
2258 any modified or waived enforcement pursuant to subsection (e). The division shall incorporate
2259 all adjustments, including, but not limited to, updates or corrections or final settlement amounts,
2260 by prospective adjustment rather than by retrospective payments or assessments. In the event of

2261 late payment by an administrative surcharge payer, the treasurer shall advance the amount of due
2262 and unpaid funds to the division prior to the receipt of such monies in anticipation of such
2263 revenues up to the amount authorized in the then current budget attributable to the administrative
2264 surcharge, and the division shall reimburse the treasurer for such advances upon receipt of such
2265 revenues. The provisions of this paragraph shall not apply to any state institution or to any acute
2266 hospital which is operated by a city or town.

2267 (c) Each acute hospital, ambulatory surgical center, ACO and physician organization shall bill an
2268 administrative surcharge payer an amount equal to the administrative surcharge described in this
2269 section as a separate and identifiable amount distinct from any amount paid by an administrative
2270 surcharge payer for acute hospital, ambulatory surgical center, ACO or physician organization
2271 services, and as a separate and identifiable amount distinct from any surcharge paid under
2272 section 38. Each administrative surcharge payer shall pay the administrative surcharge amount to
2273 the division. Each administrative surcharge payer shall make a preliminary payment to the
2274 division on October first of each year in an amount equal to one-half of the previous year's
2275 administrative surcharge amount. Thereafter, each administrative surcharge payer shall pay,
2276 within 30 days of the date of notice from the division, the balance of the total administrative
2277 surcharge amount for the current year. Upon the written request of an administrative surcharge
2278 payer, the division may implement another billing or collection method for the surcharge payer,
2279 provided, however, that the division has received all information that it requests which is
2280 necessary to implement such billing or collection method, and provided further, that the division
2281 shall specify by regulation the criteria for reviewing and approving such requests and the
2282 elements of such alternative method or methods.

2283 (d) The division shall specify by regulation appropriate mechanisms that provide for
2284 determination and payment of an administrative surcharge payer's liability, including
2285 requirements for data to be submitted by administrative surcharge payers, ambulatory surgical
2286 center, acute hospitals, ACOs and physician organizations.

2287 (e) An administrative surcharge payer's liability to the commonwealth shall in the case of a
2288 transfer of ownership be assumed by the successor in interest to the administrative surcharge
2289 payer.

2290 (f) The division shall establish by regulation an appropriate mechanism for enforcing an
2291 administrative surcharge payer's liability to the division if an administrative surcharge payer
2292 does not make a scheduled payment to the fund; provided, however, that the division may, for
2293 the purpose of administrative simplicity, establish threshold liability amounts below which
2294 enforcement may be modified or waived. Such enforcement mechanism may include assessment
2295 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent
2296 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement
2297 mechanism may also include notification to the office of Medicaid requiring an offset of
2298 payments on the claims of the administrative surcharge payer, any entity under common
2299 ownership or any successor in interest to the administrative surcharge payer, from the office of
2300 Medicaid in the amount of payment owed to the commonwealth including any interest and
2301 penalties, and to transfer the withheld funds to the commonwealth. If the office of Medicaid
2302 offsets claims payments as ordered by the division, the office of Medicaid shall be considered
2303 not to be in breach of contract or any other obligation for payment of non-contracted services,
2304 and an administrative surcharge payer whose payment is offset under an order of the division
2305 shall serve all Title XIX recipients under the contract then in effect with the executive office of

2306 health and human services. In no event shall the division direct the office of Medicaid to offset
2307 claims unless the administrative surcharge payer has maintained an outstanding liability to the
2308 fund for a period longer than 45 days and has received proper notice that the division intends to
2309 initiate enforcement actions under regulations promulgated by the division.

2310 (g) If an administrative surcharge payer, ambulatory surgical center, acute hospital, ACO or
2311 physician organization fails to file any data, statistics or schedules or other information required
2312 under subsection (c) or by any regulation promulgated by the division in connection with the
2313 administrative surcharge, the division shall provide written notice to the administrative surcharge
2314 payer, ambulatory surgical center, acute hospital, ACO or physician organization, as the case
2315 may be. If an administrative surcharge payer, ambulatory surgical center, acute hospital, ACO or
2316 physician organization fails to provide required information within 14 days after the receipt of
2317 written notice, or falsifies the same, he shall be subject to a civil penalty of not more than $5,000
2318 for each day on which the violation occurs or continues, which penalty may be assessed in an
2319 action brought on behalf of the commonwealth in any court of competent jurisdiction. The
2320 attorney general shall bring any appropriate action, including injunctive relief, necessary for the
2321 enforcement of this chapter.

2322 Section 66. Every health care provider, as defined in section 1, shall track and report quality
2323 information at least annually under regulations promulgated by the division. The division shall
2324 disclose quality information collected under this section and section 51H of chapter 111 to
2325 providers defined by said division.

2326 SECTION 122. Chapter 118H of the General Laws is hereby amended by adding the following
2327 section:-

2328 Section 7. The commonwealth care health insurance program shall attribute every enrollee to a
2329 primary care provider.

2330 SECTION 123. The General Laws are hereby amended by inserting after chapter 118H the
2331 following chapter:—

2332 CHAPTER 118I.

2333 HEALTH INFORMATION TECHNOLOGY

2334 Section 1. As used in this chapter, the following words shall, unless the context clearly requires
2335 otherwise, have the following meanings:—

2336 "Council", the health information technology council established under section 2.

2337 "Division", the division of health care cost and quality established under chapter 118G.

2338 "Electronic health record," an electronic record of patient health information generated by one or
2339 more encounters in any care delivery setting.

2340 "Executive office", the executive office of health and human services.

2341 "Longitudinal medical record", a patient's lifetime electronic health record whether located,
2342 maintained or stored on a provider server, at a central storage repository, or distributed in
2343 multiple locations but accessible with patient consent.

2344 "Health information exchange," an electronic platform enabling the transmission of healthcare-
2345 related data among providers, payers, personal health records controlled by a patient and
2346 government agencies according to national standards, the reliable and secure transfer of data
2347 among diverse systems and access to and retrieval of data.

2348 “Massachusetts eHealth institute” or “institute”, the Massachusetts eHealth institute as created in
2349 section 3.

2350 “Office of the National Coordinator” or “ONC”, the Office of the National Coordinator for
2351 Health Information Technology within the U.S Department of Health and Human Services.

2352 “Statewide health information exchange”, a health information exchange established, operated or
2353 funded by a governmental entity or entities in the commonwealth.

2354 Section 2. (a) There shall be established a health information technology council within the
2355 executive office of health and human services. The council shall coordinate with state agencies,
2356 including the division, other governmental entities and private stakeholders to develop a
2357 statewide health information exchange. The council shall advise the executive office on design,
2358 implementation, operation and use of the statewide health information exchange and related
2359 infrastructure.

2360 (b) The council shall consist of 20 members, as follows: 1 shall be the secretary of health and
2361 human services or designee, who shall serve as the chair; 1 shall be the secretary of
2362 administration and finance or designee; 1 shall be the executive director of the division of health
2363 care cost and quality or designee; 1 shall be the secretary of housing and economic development
2364 or designee; 1 shall be the director of the office of Medicaid or designee; 1 shall be the
2365 commissioner of public health or designee; 1 of whom shall be a registered nurse; and 13 shall
2366 be appointed by the governor, of whom at least 1 shall be an expert in health information
2367 technology, 1 shall be an expert in law and health policy, and 1 shall be an expert in health
2368 information privacy and security; 1 shall be from an academic medical center; 1 shall be from a
2369 community hospital; 1 shall be from a community health center; 1 shall be from a long term care

2370 facility; 1 shall be a from large physician group practice; 1 shall be from a small physician group
2371 practice; 1 shall represent health insurance carriers; and 3 additional members shall have
2372 experience or expertise in health information technology. The council may consult with all
2373 relevant parties, public or private, in exercising its duties under this section, including persons
2374 with expertise and experience in the development and dissemination of electronic health records
2375 systems, and the implementation of electronic health record systems by small physician groups
2376 or ambulatory care providers, as well as persons representing organizations within the
2377 commonwealth interested in and affected by the development of networks and electronic health
2378 records systems, including, but not limited to, persons representing local public health agencies,
2379 licensed hospitals and other licensed facilities and providers, private purchasers, the medical and
2380 nursing professions, physicians and health insurers, the state quality improvement organization,
2381 academic and research institutions, consumer advisory organizations with expertise in health
2382 information technology and other stakeholders as identified by the secretary of health and human
2383 services. Appointive members of the council shall serve for terms of 2 years or until a successor
2384 is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

2385 Chapter 268A shall apply to all council members, except that the council may purchase from,
2386 sell to, borrow from, contract with or otherwise deal with any organization in which any council
2387 member is in anyway interested or involved; provided, however, that such interest or
2388 involvement shall be disclosed in advance to the council and recorded in the minutes of the
2389 proceedings of the council; and provided, further, that no member shall be deemed to have
2390 violated section 4 of said chapter 268A because of his or her receipt of his or her usual and
2391 regular compensation from his or her employer during the time in which the member participates
2392 in the activities of the council.

2393 Section 3. (a) There shall be established within the division an institute for health care
2394 innovation, technology and competitiveness, to be known as the Massachusetts e-Health
2395 Institute. The executive director of the division shall appoint a qualified individual to serve as the
2396 director of the institute, who shall be an employee of the division, report to the executive director
2397 and manage the affairs of the institute. The institute shall advance the dissemination of health
2398 information technology across the commonwealth, including the deployment of electronic health
2399 records systems in all health care provider settings that are networked through a statewide health
2400 information exchange. The institute shall (i) conduct the regional extension center program for
2401 the coordination and implementation of electronic health records systems by providers; (ii) fulfill
2402 its current and any future contract obligations with the Office of Medicaid to administer specific
2403 operational components of the MassHealth electronic health records incentive program; and (iii)
2404 develop a plan to complete the implementation electronic health records systems by all providers
2405 in the commonwealth.

2406 Section 4. (a) The executive office shall conduct procurements and enter into contracts for the
2407 purchase and development of any and all hardware or software in connection with the creation
2408 and implementation of the statewide health information exchange. The executive office shall
2409 have authority, in consultation with the council and the division, over the technical aspects of the
2410 development, dissemination and implementation of the statewide health information exchange
2411 including any modules, applications, interfaces or other technology infrastructure necessary to
2412 connect provider electronic health records systems to the statewide health information exchange.

2413 (b) The executive office shall:

2414 (i) in consultation with the council, develop a health information exchange strategic and
2415 operating plan;

2416 (ii) implement, operate and maintain the statewide health information exchange;

2417 (iii) develop and implement statewide health information exchange infrastructure,
2418 including, without limitation, provider directories, certificate storage, transmission gateways,
2419 auditing systems and any components necessary to connect the statewide health information
2420 exchange to provider electronic health records systems; and

2421 (iv) take all actions necessary to directly manage the Office of the National Coordinator-
2422 HIE Cooperative Agreement and ONC Challenge Grant programs, including the termination of
2423 the current State Designated Entity delegation and the transfer of management responsibility of
2424 said ONC-HIE Cooperative Agreement from the Massachusetts eHealth Institute to the executive
2425 office.

2426 Section 5. (a) The council, in consultation with the executive office and the institute, shall
2427 advance the dissemination of health information technology by: (i) ensuring the implementation
2428 and use of electronic health records systems by health care providers in order to improve health
2429 care delivery and coordination, reduce unwarranted treatment variation, eliminate wasteful
2430 paper-based processes, help facilitate chronic disease management initiatives and establish
2431 transparency; (ii) ensuring the creation and maintenance of a statewide interoperable electronic
2432 health information exchange that allows individual health care providers in all health care
2433 settings to exchange patient health information with other providers; and (iii) identifying and
2434 promoting an accelerated dissemination in the commonwealth of emerging health care
2435 technologies that have been developed and employed and that are expected to improve health

2436 care quality and lower health care costs, but that have not been widely implemented in the
2437 commonwealth.

2438 (b) In carrying out the purposes of this section, the council shall consult with various
2439 organizations of regional payers and providers involved in the development of a health
2440 information exchange in developing the statewide electronic records plan and annual updates and
2441 in designing, developing, disseminating and implementing health information technology.

2442 (c) In carrying out the purposes of this section, the executive office shall, to the maximum extent
2443 practicable, adopt policies that are consistent with those relating to similar subject matters
2444 adopted by the Office of the National Coordinator for Health Information Technology of the
2445 federal Department of Health and Human Services; provided, however, that nothing herein shall
2446 be construed to limit the executive office's ability to advance interoperability and other health
2447 information technology beyond the standards adopted by the ONC, including without limitation
2448 any applicable meaningful use standards.

2449 Section 6. (a)(1) The council shall approve all expenditures from the Massachusetts Health
2450 Information Exchange Fund established under section 11. The council, in consultation with the
2451 executive office and institute, shall prepare and annually update a statewide health information
2452 exchange implementation plan. The plan shall contain a budget for the application of funds from
2453 the Massachusetts Health Information Exchange Fund for use in implementing such plan.

2454 (2) The institute shall approve all expenditures from the Massachusetts Health Information
2455 Technology Fund established under section 12. The institute, in consultation with the executive
2456 office and council, shall prepare an electronic health record plan for the implementation of
2457 electronic health records systems by all providers in the commonwealth. The plan shall contain a

2458 budget for the application of funds from the Massachusetts Health Information Technology Fund
2459 for use in implementing such plan.

2460 (b) Components of each such plan, as updated, shall be community-based implementation plans
2461 that assess a municipality's or region's readiness to implement and use electronic health record
2462 systems and an interoperable electronic health information exchange within the referral market
2463 for a defined patient population. Each such implementation plan shall address the development,
2464 implementation and dissemination of electronic health records systems among health care
2465 providers in the community or region, particularly providers, such as community health centers
2466 and community based behavioral health provider organizations that serve underserved
2467 populations, including, but not limited to, racial, ethnic and linguistic minorities, uninsured
2468 persons, and areas with a high proportion of public payer care.

2469 (c) Each plan as updated shall: (i) allow seamless, secure electronic exchange of health
2470 information among health care providers, health plans and other authorized users; (ii) provide
2471 consumers with secure, electronic access to their own health information; (iii) meet all applicable
2472 federal and state privacy and security requirements, including requirements imposed by the
2473 Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American
2474 Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R.
2475 §§160, 162, 164 and 170.; (iv) establish a method by which patients may choose which of their
2476 health care providers may disseminate their individually identifiable information; (v) provide
2477 public health reporting capability as required under state law; and (vi) allow reporting of health
2478 information other than identifiable patient health information for purposes of such activities as
2479 the executive office may from time to time consider necessary.

2480 (d) Each plan as updated shall be consistent with the mandatory compliance date set forth in
2481 section 8 for implementation of the health information exchange and all other requirements of
2482 this act.

2483 Section 7. Every patient shall have electronic access to his or her records at all times. The
2484 executive office shall ensure that each patient will have secure electronic access to such patient's
2485 electronic health records with each of such patient's providers. The executive office shall ensure
2486 that the design of the statewide health information exchange includes the ability to transmit
2487 copies of electronic health records to patients directly or allow facilities to provide mechanisms
2488 for such patient to access his or her own electronic health record.

2489 Section 8. All providers in the commonwealth shall implement fully interoperable electronic
2490 health records systems that connect to the statewide health information exchange. The executive
2491 office shall ensure that the statewide health information exchange and associated electronic
2492 health records systems comply with all state and federal privacy requirements, including those
2493 imposed by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the
2494 American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45
2495 C.F.R.§§160, 162 and 164.

2496 Section 9. The executive office is authorized to impose penalties for non-compliance by
2497 healthcare providers with the requirements of section 8 of up to $1 per day per member, for a
2498 maximum of 45 days; provided, however, that the executive office may waive penalties for good
2499 cause shown, including, but not limited to lack of broadband internet access as provided in
2500 section 10. Penalties collected under this section shall be deposited into the wellness and
2501 prevention trust fund, established in section 75 of chapter 10.

2502 Section 10. If a provider is located in a geographic area of the commonwealth that does not have
2503 broadband internet access and, due to lack of such broadband internet access, such provider is
2504 unable to fully comply with the requirements of the health information exchange and any other
2505 health information technology requirements implemented by the executive office under this
2506 chapter, such provider may apply to the executive office for a temporary waiver of any specific
2507 requirement with which it is unable to comply. If the executive office determines that the
2508 provider is unable to comply with a requirement due to the lack of broadband internet access, the
2509 executive office may grant a waiver of such requirement; provided, however, that, upon a
2510 determination by the executive office that broadband internet access has become available to
2511 such provider since the date of the grant of the waiver, the executive office shall notify such
2512 provider thereof. Within 180 days of such notice, such provider shall take such actions as are
2513 necessary to bring the provider into full compliance with the requirements of the health
2514 information exchange and any other health information technology requirements implemented by
2515 the executive office under this chapter.

2516 Section 11. There shall be established and set up on the books of the executive office the
2517 Massachusetts Health Information Exchange Fund, referred to in this section as the fund, for the
2518 purpose of supporting the advancement of health information technology in the commonwealth.
2519 There shall be credited to the fund any appropriations, proceeds of any bonds or notes of the
2520 commonwealth issued for the purpose, or other monies authorized by the general court and
2521 designated thereto; any federal grants or loans; any private gifts, grants or donations made
2522 available; and any income derived from the investment of amounts credited to the fund. The
2523 executive office shall seek, to the greatest extent possible, private gifts, grants and donations to
2524 the fund. The executive office shall hold the fund in an account or accounts separate from other

2525 funds. The fund shall be administered by the executive office without further appropriation.
2526 Amounts credited to the fund shall be available for reasonable expenditure by the executive
2527 office, subject to the approval of the council where such approval is required under this chapter,
2528 for such purposes as the executive office determines are necessary to support the dissemination
2529 and development of the statewide health information exchange. The secretary of administration
2530 and finance shall transfer a portion of (i) any money in the E-Health Institute Fund, (ii) any
2531 money from the ONC Health Information Exchange Cooperative Agreement, or (iii) the ONC
2532 Health Information Exchange Challenge Grant programs that is related to the implementation of
2533 the statewide health information exchange.

2534 Section 12. There shall be established and set up on the books of the division the Massachusetts
2535 Health Information Technology Fund, referred to in this section as the fund, for the purpose of
2536 supporting the advancement of electronic health records in the commonwealth. There shall be
2537 credited to the fund any appropriations, proceeds of any bonds or notes of the commonwealth
2538 issued for the purpose, or other monies authorized by the general court and designated thereto;
2539 any federal grants or loans; any private gifts, grants or donations made available; and any income
2540 derived from the investment of amounts credited to the fund. The division shall seek, to the
2541 greatest extent possible, private gifts, grants and donations to the fund. The division shall hold
2542 the fund in an account or accounts separate from other funds. The fund shall be administered by
2543 the division without further appropriation. Amounts credited to the fund shall be available for
2544 reasonable expenditure by the institute, subject to the approval of the division where such
2545 approval is required under this chapter, for such purposes as the institute determines are
2546 necessary to support the dissemination, development, and deployment of the electronic health
2547 records in the commonwealth. The secretary of administration and finance shall transfer a

2548 portion of (i) monies in the E-Health Institute Fund, (ii) monies from the ONC Regional
2549 Extension Center Cooperative Agreement, or (iii) monies from the MassHealth EHR-IP contract
2550 that is related to the operation of the institute and its status as the state designated regional
2551 extension center.

2552 Section 13. Any plan approved by the executive office and institute or every grantee and
2553 implementing organization that receives monies for the adoption of health information
2554 technology shall:

2555 (1) establish a mechanism to allow patients to opt-in to the health information exchange and to
2556 opt-out at any time, including a separate opt-in mechanism relative to information pertaining to
2557 health conditions associated with the human immunodeficiency virus.

2558 (2) maintain identifiable health information in physically and technologically secure
2559 environments by means including, but not limited to: prohibiting the storage or transfer of
2560 unencrypted and non-password protected identifiable health information on portable data storage
2561 devices; requiring data encryption, unique alpha-numerical identifiers and password protection;
2562 and other methods to prevent unauthorized access to identifiable health information;

2563 (3) provide patients the option of, upon request to a provider, obtaining a list of individuals and
2564 entities that have accessed their identifiable health information from that provider;

2565 (4) develop and distribute to authorized users of the health information exchange and to
2566 prospective exchange participants, written guidelines addressing privacy, confidentiality and
2567 security of health information and inform individuals of what information about them is
2568 available, who may access their information, and the purposes for which their information may
2569 be accessed; and

2570 (5) ensure compliance with all state and federal privacy requirements, including those imposed
2571 by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American
2572 Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45
2573 C.F.R.§§160, 162 and 164.

2574 Section 14. In the event of an unauthorized access to or disclosure of individually identifiable
2575 patient health information by or through the statewide health information exchange or by or
2576 through any technology grantees or implementing organizations funded in whole or in part from
2577 the Massachusetts Health Information Technology Fund established pursuant to section 12, the
2578 operator of such exchange or grantee or contractor shall: (i) report the conditions of such
2579 unauthorized access or disclosure as required by the executive office; and (ii) provide notice, as
2580 defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days
2581 after such unauthorized access or disclosure, to any person whose patient health information may
2582 have been compromised as a result of such unauthorized access or disclosure, and shall report the
2583 conditions of such unauthorized access or disclosure. Any unauthorized access or disclosures
2584 shall be punishable by the civil penalties as set forth in section 19.

2585 Section 15. The ability of any provider to transfer or access all or any part of a patient's
2586 electronic health record under the provisions of this chapter shall be subject to the patient's
2587 election to participate in the electronic health information exchange as provided in section 13.
2588 Such ability shall also be subject to a separate required election to participate as to any
2589 information relating to human immunodeficiency virus status. No patient may be refused care for
2590 opting out of the health information exchange, or for withholding their HIV related information
2591 from the health information exchange.

2592 Section 16. Funding for electronic health records and health information exchange development
2593 and implementation under this chapter shall be, in part, through the Massachusetts Health
2594 Information Technology Fund, established in section 12. The council shall develop mechanisms
2595 for funding health information technology, including grant and no interest loan programs as
2596 provided in this section and section 18 to assist health care providers with costs associated with
2597 health information technologies, including electronic health records systems, and coordinating
2598 with other electronic health records projects seeking federal reimbursement.

2599 The executive office, the council and the institute shall pursue and maximize all opportunities to
2600 qualify for federal financial participation under the matching grant program established under the
2601 Health Information Technology for Economic and Clinical Health Act of the American Recovery
2602 and Reinvestment Act of 2009, P.L. 111-5. The council shall consult with the office of Medicaid
2603 to maximize all opportunities to qualify any expenditure for any other federal financial
2604 participation. Applications for funding shall be in the form and manner determined by the
2605 council, and shall include the information and assurances required by the council. The council
2606 may consider, as a condition for awarding grants, the grantee's financial participation whether the
2607 grantee serves a high proportion of public payer clients, whether the grantee is eligible to receive
2608 Medicare or Medicaid incentive payments under the federal Health Information Technology for
2609 Economic and Clinical Health Act and any other factors it deems relevant.

2610 All grants shall be recommended by the council and approved by the executive office.. Each
2611 recipient of monies from this program shall: (i) capture and report certain quality improvement
2612 data, as determined by the council; (ii) implement the system fully, including all clinical features,
2613 not later than the second year of the grant; and (iii) make use of the system's full range of
2614 features.

2615 Section 17. The council shall file an annual report, not later than January 30, with the joint
2616 committee on health care financing, and the house and senate committees on ways and means
2617 concerning the activities of the council in general and, in particular, describing the progress to
2618 date in implementing a statewide electronic health records system and recommending such
2619 further legislative action as it deems appropriate.

2620 Section 18. (a) The state comptroller shall establish and set up on the books of the
2621 commonwealth the Massachusetts Health Information Technology Revolving Loan Fund,
2622 hereinafter referred to as the fund, for the purpose of providing loan assistance to healthcare
2623 providers including but not limited to those, defined in section 1 of chapter 111 and to
2624 community based behavioral health organizations, to pay the costs associated with compliance
2625 with state and federal requirements relative to the implementation of health care information
2626 technology in the commonwealth, including, but not limited to, the costs of purchasing, installing
2627 and implementing electronic health records systems and other health information technology
2628 required by state or federal law. There shall be credited to the fund any appropriations, proceeds
2629 of any bonds or notes of the commonwealth issued for the purpose, or other monies authorized
2630 by the general court and designated thereto; any federal grants or loans; any private gifts, grants
2631 or donations made available; and any income derived from the investment of amounts credited to
2632 the fund. The executive office shall pursue and maximize all opportunities to qualify for federal
2633 financial participation under the matching grant program established under section 3013 of the
2634 Health Information Technology for Economic and Clinical Health Act of the American Recovery
2635 and Reinvestment Act of 2009, P.L. 111-5. The department shall seek, to the greatest extent
2636 possible, private gifts, grants and donations to the fund. The fund shall be held in an account or
2637 accounts separate from other funds. The fund shall be administered by the executive office

2638 without further appropriation. Amounts credited to the fund shall be available for reasonable
2639 expenditure by the executive office, for such purposes as the executive office determines are
2640 necessary to support the dissemination and development of health information technology in the
2641 commonwealth, including, but not limited to, the loan program established in this section. Any
2642 funds remaining in the fund at the end of a fiscal year shall be carried forward into the following
2643 fiscal year and shall remain available for expenditure without further appropriation.

2644 (b) The executive office shall make available zero interest loan funding from the Massachusetts
2645 health information technology revolving loan fund to healthcare providers including but not
2646 limited to those, defined in section 1 of chapter 118G and to community based behavioral health
2647 organizations, to assist with the development and implementation of an interoperable health
2648 information technology system that meets all federal and state requirements; provided, further
2649 that the executive office shall make said loan funding available to providers of
2650 rehabilitative/habilitative services such as physical therapy, occupational therapy and prosthetics
2651 and orthotics practitioners. The executive office shall make such loans available through banks
2652 approved to do business in the commonwealth by the division of banks. The executive office
2653 shall enter into agreements with such lenders to make loans. The executive office, in
2654 consultation with the state treasurer, shall develop a lender partnership program and lender
2655 agreement that requires, at a minimum, (i) that a bank must be adequately capitalized, consistent
2656 with the requirements of 209 CMR 47.00 et seq. and as defined under the prompt corrective
2657 action provisions of the Federal Deposit Insurance Act, 12 U.S.C. section 1831(o), and the
2658 Federal Deposit Insurance Corporation's Capital Adequacy Regulations, 12 CFR section
2659 325.103; (ii) the executive office shall specify lending standards, including without limitation,
2660 those for determining eligibility, including the eligibility standards set forth in this subsection,

2661 size and number of loans, and (iii) that all loans made under the program must be zero interest
2662 loans provided, however, that any such program may provide for reasonable application and
2663 administrative fees to be paid to lending banks under the program. A reasonable amount of
2664 administrative costs may be expended annually from the fund for the administration of the
2665 program. Any application or other fees imposed and collected under this program shall be
2666 deposited in the Massachusetts Health Information Technology Revolving Loan Fund for the
2667 duration of the loan program. The executive office may make such adjustments as are necessary
2668 to loan applications to account for reimbursements received under any other state or federal
2669 programs. To be eligible for a loan under this section, a healthcare provider, at a minimum, shall
2670 provide the participating lending institution with the following information: (1) the amount of the
2671 loan requested and a description of the purpose or project for which the loan proceeds will be
2672 used; (2) a price quote from a vendor; (3) a description of the health care provider or entities and
2673 other groups participating in the project; (4) evidence of financial condition and ability to repay
2674 the loan; and (5) a description of how the loan funds will be used to bring the healthcare provider
2675 into compliance with federal and state requirements. Loans shall be repaid over a 5-year term
2676 according to a schedule to be established through division regulations. The attorney general shall
2677 enforce collection of any loans in default.

2678 The executive office shall promulgate regulations necessary for the operation of this program.

2679 Section 19. Unauthorized access to or disclosure of individually identifiable patient health
2680 information by or through the statewide health information exchange or by or through any
2681 technology grantees or implementing organizations funded in whole or in part from the
2682 Massachusetts Health Information Technology Fund established pursuant to section 12, or any
2683 associated businesses managing or in possession of such information, the operator of such

2684 exchange or grantee or contractor shall be subject to fines or penalties as determined by the
2685 executive office. The executive office shall promulgate regulations to assess fair and reasonable
2686 fines or penalties.

2687 Section 20. The division shall adopt regulations requiring hospitals, clinics, and health care
2688 networks to implement evidence-based best practice clinical decision support tools for the
2689 ordering provider of advanced diagnostic imaging services by January 1, 2017. The clinical
2690 decision support guidelines and protocols developed by the division shall be incorporated into
2691 the provider order entry systems of hospitals and the electronic health records of providers, to the
2692 maximum extent possible for certified EHR technology. The use of such decision support tools
2693 shall meet the privacy and security standards promulgated pursuant to the federal Health
2694 Insurance Portability and Accountability Act of 1996 (Public Law 104-119).

2695 In addition, the division shall advance the dissemination of innovative technologies, including,
2696 but not limited to, those technologies that would allow diagnostic imaging exams to be
2697 seamlessly processed and transferred electronically through means that may include, but shall
2698 not be limited to, cloud-based technologies.

2699 For the purpose of this section, advanced diagnostic imaging services shall include computerized
2700 tomography, magnetic resonance imaging, magnetic resonance angiography, positron emission
2701 tomography, cardiac imaging, and such other imaging services as may be determined by the
2702 division.

2703 SECTION 124. The General Laws are hereby amended by inserting after chapter 118I the
2704 following chapter:-

2705 CHAPTER 118J.

2706 ACCOUNTABLE CARE ORGANIZATIONS

2707 Section 1. As used in this chapter, the following words shall, unless the context clearly requires
2708 gotherwise, have the following meanings:—

2709 "Accountable care organization" or "ACO", an entity comprised of health care providers
2710 organized into an integrated organization that accepts shared risk for the cost and quality of a
2711 patient's well being. An ACO may be licensed under this chapter, provided that any and all
2712 regulations promulgated by the division shall be consistent with federal law, regulations,
2713 demonstrations and rules governing accountable care organizations and shared savings programs.

2714 "ACO participant", a health care provider that either integrates or contracts with an ACO to
2715 provide services to ACO patients.

2716 "ACO patient", an individual who chooses or is attributed to an ACO for his or her medical and
2717 behavioral health care, for whom such services are paid by the payer to the ACO.

2718 "Alternative payment methodology", methods of payment defined in Section 1 of chapter 118G.

2719 "Division", the division of health care cost and quality, as enabled in chapter 118G.

2720 "Executive director", the executive director of the division of health care cost and quality, as
2721 enabled in chapter 118G.

2722 "Health care provider", a provider of medical of health services and any other person or
2723 organization, including an ACO, that furnishes, bills, or is paid for health care service delivery in
2724 the normal course of business.

2725 “Office of patient protection”, the office within the division of health care cost and quality
2726 established under section 63 of chapter 118G.

2727 “Patient centered medical home”, a model of health care delivery designed to provide a patient
2728 with a single point of coordination for all their health care, including primary, specialty, post-
2729 acute and chronic care, which is (a) patient-centered; (b) comprehensive, integrated and
2730 continuous; and (c) delivered by a team of health care professionals to manage a patient’s care,
2731 reduce fragmentation, and improve patient outcomes.

2732 “Payer”, any entity, other than an individual, that pays providers or ACOs for the provision of
2733 health care services. “Payer” shall include both governmental and private entities, but exclude
2734 ERISA plans.

2735 “Physician”, a medical doctor licensed to practice medicine in the commonwealth.

2736 “Primary care physician”, a physician who has a primary specialty designation of internal
2737 medicine, general practice, family practice, pediatric practice or geriatric practice.

2738 Section 2. (a) The division shall be responsible for the licensing of ACOs. A license shall be
2739 issued for a term of 2 years and renewable under like terms. An ACO shall be in compliance
2740 with all state and federal laws such as the Americans with Disabilities Act, Health Information
2741 Privacy and Accountability Act, and Patient Protection and Affordable Care Act. The division
2742 shall develop the process for licensing ACOs.

2743 (b) A licensed ACO shall, at a minimum, meet the following criteria:

2744 (1) be a separate legal entity as required in section 3;

2745 (2) submit a collaborative care plan as defined in section 4;

2746 (3) meet the functional capabilities under section 6;

2747 (4) have a governance structure under section 7;

2748 (5) meet the criteria for size under section 8;

2749 (6) obtain interoperable health information technology under section 9;

2750 (7) meet the quality reporting requirements under section 10;

2751 (8) obtain a risk certificate from the division of insurance as defined by section 12;

2752 (9) create internal consumer protection guidelines as defined in section 13; and

2753 (10) meet pricing reporting requirements under section 15.

2754 (c) The division may include additional requirements as necessary to promote patient safety and
2755 fiscal solvency for ACO licensure.

2756 (d) No later than 30 days after an application has been filed, the division may require the ACO
2757 applicant to provide additional information to complete or supplement the filing.

2758 (e) Within 45 days of receipt of a complete application, the division shall complete its review of
2759 the application and send written notice to the ACO, with a copy to the division of insurance,
2760 explaining its decision to: (1) issue the license as applied for, (2) reject the application for failure
2761 to comply with the requirements of the application process, with instructions that the application
2762 may be resubmitted within 10 days; or (3) deny the application.

2763 (f) Any ACO's whose application has been rejected or denied may request an adjudicatory
2764 hearing pursuant to chapter 30A within 21 days of the division's decision. The division shall

2765 notify the attorney general and the division of insurance upon receipt of such hearing request.
2766 Said hearing shall be conducted within 30 days of the division's receipt of the hearing request.
2767 The attorney general may intervene in a hearing under this subsection and may require the
2768 production of additional information or testimony. The commissioner shall issue a written
2769 decision within 30 days of the conclusion of the hearing.

2770 (g) An ACO aggrieved by said written decision may, within 20 days of said decision, file a
2771 petition for review in the Suffolk superior court. Review by the supreme judicial court on the
2772 merits shall be limited to the record of the proceedings before the commissioner and shall be
2773 based upon the standards set forth in paragraph (7) of section 14 of chapter 30A.

2774 Section 3. An ACO shall be organized or registered in the commonwealth.

2775 Section 4. ACOs shall accept and share among their ACO participants responsibility for the
2776 delivery, management, quality, and cost of the provision of at least all integrated health care
2777 services, as such terms are defined by the division's authority under section 6, to ACO patients.
2778 The ACO shall submit a collaborative care plan for integrating physical and behavioral health
2779 services.

2780 Section 5. ACOs shall be compensated by an alternative payment methodology for each ACO
2781 patient receiving services through the ACO, in accordance with this chapter; provided that any
2782 and all regulations promulgated by the division shall be consistent with federal law, regulations,
2783 demonstrations and rules governing accountable care organizations and shared savings programs.

2784 Section 6. ACOs shall, at a minimum, provide or obtain through contractual arrangements the
2785 following functional capacities:

2786 (a) clinical service coordination, management, and delivery functions, including the ability to
2787 provide integrated health care services through its ACO participant network in accordance with
2788 the principles of a patient centered medical home; provided that clinical service coordination
2789 may be managed by a physician, nurse practitioner, registered nurse, physician assistant, or
2790 social worker;

2791 (b) population management functions, including health information technology and data analysis
2792 tools, to provide at least: (1) patient-specific encounter data and (2) management reports on
2793 aggregate data;

2794 (c) financial management capabilities, including, but not limited to, the management of claims
2795 processing and payment functions for ACO participants;

2796 (d) contract management capabilities, including, but not limited to, ACO participant contracting
2797 and management functions;

2798 (e) quality measure competence, including, but not limited to, the ability to measure and report
2799 performance relative to established measures of quality and performance under standard quality
2800 measures as determined under section 10.

2801 (f) provider to provider communications functions;

2802 (g) the ability to provide chronic disease management either internally within the ACO or by
2803 contractual agreement;

2804 (h) the ability to provide behavioral health services either internally within the ACO or by
2805 contractual agreement;

2806 (i) the ability to engage patients in shared decision making processes, including but not limited
2807 to decisions on long-term-care and supports and palliative care;

2808 (j) Contract with providers for any other medically necessary, but unavailable within the ACO,
2809 services or provide the patient with the ability to receive such services outside of the ACO; and

2810 (k) Ensure patient access to health care services, including breakthrough technologies and human
2811 therapeutic treatments.

2812 Section 7. (a) An ACO's organizational structure shall include a governance body, executive
2813 officer, and a medical director.

2814 (b) The governance body shall be identifiable and have the following authority and
2815 responsibilities:

2816 (1) the governance body shall be responsible for oversight and strategic direction of the ACO,
2817 holding the management accountable for the ACO's activities;

2818 (2) the governance body shall have a defined governing process and its decisions shall be
2819 documented;

2820 (3) the governance body members shall have a fiduciary duty to the ACO entity and shall act
2821 consistently with that fiduciary duty;

2822 (4) the governance body shall be separate and unique to the ACO in cases where the ACO
2823 comprises of multiple, otherwise independent ACO participants; and

2824 (5) if the ACO is an existing entity, the governing body may be the same as the existing entity
2825 provided it satisfies the other requirements of this section.

2826 (c) The governance body shall adhere to the following rules:

2827 (1) at least 75 per cent of the body's control shall be held by ACO participants;

2828 (2) the members of the governance body may serve in a similar or complementary manner for an
2829 ACO participant;

2830 (3) members of the governance body shall not have a financial conflict of interest;

2831 (4) the governance body shall include at least 1 patient who does not have a financial conflict of
2832 interest with the ACO; and

2833 (5) the division shall have the discretion to allow a waiver and shall promulgate regulations for
2834 the possibility of waiving any of these requirements.

2835 (d) The executive officer shall be responsible for the administrative and operational systems to
2836 align the ACO with the goals of improving access, improving quality and reducing costs of
2837 health care. The executive officer may be an executive, officer, manager, or general partner. The
2838 executive officer shall consult with the medical director to ensure care coordination and quality.

2839 (e) The medical director shall be responsible for the clinical management and oversight of the
2840 ACO. The medical director shall be a board-certified and licensed physician in the
2841 commonwealth. The medical director shall be an active ACO participant who is physically
2842 present on a regular basis at any clinic, office, or other location participating in the ACO.

2843 Section 8. (a) An ACO shall have a minimum of 30,000 covered lives within the commonwealth.
2844 A patient shall voluntarily select to join an ACO and shall count as a covered life for that ACO.
2845 An ACO may not exclude a patient who receives coverage through a program offered by the
2846 division of medical assistance.

2847 (b) An ACO shall have a cap of 800,000 covered lives within the commonwealth. They may
2848 waive this requirement under the following conditions:

2849 (1) the ACO demonstrates an improvement in quality to the division; and

2850 (2) the ACO shows a reduction in total medical expenses to the division.

2851 (c) The division, in consultation with the division of insurance, shall create an annual open
2852 enrollment period for a patient to join an ACO. This period shall last no less than 1 month and no
2853 longer than 2 months. The division shall allow a patient to switch to an ACO once within the
2854 first 3 months of coverage after joining an ACO during the open enrollment period or following
2855 a qualifying event, provided that a patient who changes their health insurance outside of the
2856 ACO open enrollment period shall be provided an opportunity to enroll in a new ACO.

2857 Section 9. The division, in consultation with the Health Information Technology Council for
2858 technical advice, shall promulgate regulations related to electronic medical records including, but
2859 not limited to, the standards of interoperability, care coordination tools, information processes or
2860 electronic prescribing standards.

2861 Section 10. (a) The division shall use the standard quality measure set and set minimum
2862 standards that ACOs are responsible for maintaining.

2863 (b) ACOs shall report the quality measures to the division on a semi-annual basis. Failure to
2864 submit a timely report shall result in a fine of $100 per day up to $5,000 per missed reporting
2865 period.

2866 (c) The division may conduct an on-site audit of the ACO's quality reporting no more than twice
2867 a year unless the division deems additional audits are required in the interest of public safety.

2868 (d) The division may fine ACOs up to $1 per attributed member for failure to meet quality
2869 measures in each reporting period. The ACO shall create and file a quality improvement plan
2870 with the division if it fails to meet the quality measures in any given reporting period. The
2871 division may revoke an ACO's license if: (1) it fails to timely file its quality improvement plan,
2872 (2) fails to follow the quality improvement plan in a following reporting period, or (3) it fails to
2873 meet the quality measures for 3 consecutive reporting periods.

2874 (e) The division may evaluate and provide guidance to ACO's regarding the appropriate use and
2875 ordering of medically necessary testing enabled though testing protocols and clinical integration
2876 of health care providers within and outside of the organization, including, but not limited to the
2877 medical director of the clinical laboratory.

2878 Section 11. (a) Notwithstanding any other law or regulation to the contrary, the ACO shall be
2879 held liable up to the amount of $500,000 for any medical malpractice based claim against an
2880 ACO participant acting on behalf of the ACO.

2881 (b) Interest on a legal judgment against an ACO shall be assessed in accordance to section 60K
2882 of chapter 231.

2883 Section 12. The commissioner of insurance shall make a determination if an ACO has adequate
2884 reserves to meet their risk arrangements. The commissioner of insurance shall have the authority
2885 to promulgate regulations to ensure the viability of an ACO for all risks including, but not
2886 limited to, global payment or shared savings risk, and to establish financial oversight provisions
2887 and requirements for ACOs. Upon the satisfaction of the commissioner of insurance, the
2888 division of insurance shall submit a certificate of approval to the division.

2889 Section 13. The division shall create ACO appeal procedures for adverse determinations that are
2890 consistent with the appeal procedures of sections 12 through 14 of chapter 176O. These
2891 guidelines shall include the clear articulation of the appellate stages, timing requirements for
2892 each stage of appeal,and a process to provide an independent second opinion outside the ACO.
2893 The final decision within the ACO shall be completed within 14 days after the filing of a
2894 complaint by a patient. The division may require ACOs to create an ombudsman office or similar
2895 office for the protection of patients. Once appeals within the ACO have been exhausted
2896 internally, the claims shall be appealable to the office of patient protection.

2897 Section 14. Every ACO shall develop and file an internal appeals plan according to section 13.
2898 The division shall approve each plan. The plan shall be a part of a membership packet for newly
2899 enrolled individuals.

2900 Section 15. The division shall require ACOs to report pricing of services by its ACO
2901 participants. The division shall require the reporting of these prices to inform the consumer under
2902 section 51 of chapter 118G. ACO participants shall have the ability to provide patients with
2903 relevant price information when contemplating their care and potential referrals.

2904 Section 16. All accountable care organizations and any government entity that contracted with a
2905 health plan or insurer utilizing ACOs was a party to the appeals process shall publish the
2906 standards used by the ACO to determine inclusion of any provider as an ACO participant. A
2907 provider shall be informed in writing by the ACO of the standards by which they were accepted
2908 or rejected as an ACO participant.
2909 The division shall create a review process for aggrieved providers that are denied acceptance into
2910 an ACO as an ACO participant. For such process, the division may review the following: (1) a

2911 comparison of the costs of services between an aggrieved provider and ACO participants; (2) a
2912 comparison of the quality of services between an aggrieved provider and ACO participants; (3) a
2913 comparison of the efficiency of services between an aggrieved provider and ACO participants;
2914 and (4) the extent to which the aggrieved provider meets the published standards used by the
2915 ACO to determine inclusion of any provider as an ACO participant.

2916 SECTION 125. Section 14 of chapter 122 of the General Laws, as appearing in the 2010
2917 Official Edition, is hereby amended by striking out, in line 18, the words "finance and policy"
2918 and inserting in place thereof the following words:—cost and quality.

2919 SECTION 126. Section 32 of chapter 123 of the General Laws, as so appearing, is hereby
2920 amended by striking out, in line 5, the words "finance and policy" and inserting in place thereof
2921 the following words:—cost and quality.

2922 SECTION 127. Section 33 of said chapter 123, as so appearing, is hereby amended by striking
2923 out, in lines 20 and 25, the words "finance and policy" and inserting in place thereof, in each
2924 instance, the following words:—cost and quality.

2925 SECTION 128. Section 16 of chapter 123B of the General Laws, as so appearing, is hereby
2926 amended by striking out, in line 5, the words "finance and policy" and inserting in place thereof
2927 the following words:—cost and quality.

2928 SECTION 129. Section 6D½ of chapter 149 of the General Laws, as so appearing, is hereby
2929 amended by striking out, in lines 3 and 4, the words "finance and policy" and inserting in place
2930 thereof the following words:—cost and quality.

2931 SECTION 130. Said chapter 149 is hereby further amended by striking out section 188, as so
2932 appearing, and inserting in place thereof the following section:—

2933 Section 188. (a) As used in this section, the following words, unless the context clearly requires
2934 otherwise, shall have the following meanings:--

2935 “Authority”, the commonwealth health insurance connector authority.

2936 "Contributing employer", an employer that offers a group health plan, as defined in 26 U.S.C.
2937 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as defined
2938 in regulation by the authority.

2939 "Department", the department of unemployment assistance.

2940 "Employer", an employing unit as defined in section 1 of chapter 151A or in section 1 of chapter
2941 152.

2942 "Employee", any individual employed by an employer subject to this chapter for at least 1
2943 month, provided that for the purpose of this section seasonal employees and self-employed
2944 individuals shall not be considered employees.

2945 “Seasonal employee,” A seasonal employee as defined in Chapter 151A, Section 1.

2946 (b) For the purpose of more equitably distributing the costs of health care provided to uninsured
2947 residents of the commonwealth, each employer that: (1) employs 21 or more full-time equivalent
2948 employees in the commonwealth and (2) is not a contributing employer shall pay a per-employee
2949 contribution at a time and in a manner prescribed by the director of unemployment assistance, in
2950 this section called the fair share employer contribution. This contribution shall be pro-rated by a
2951 fraction which shall not exceed 1, the numerator of which is the number of hours worked in the

2952 quarter by all of the employer's employees and the denominator of which is the product of the
2953 number of employees employed by an employer during that quarter multiplied by 500 hours.

2954 (c) The executive director of the authority shall, in consultation with the director of
2955 unemployment assistance, annually determine the fair share employer contribution rate based on
2956 the best available data and under the following provisions:-

2957 (1) The per-user share of private sector liability shall be calculated annually by dividing the sum
2958 of hospital liability and third-party payor liability for uncompensated care, as defined by law, by
2959 the total number of individuals in the most recently completed fiscal year whose care was
2960 reimbursed in whole or in part by the uncompensated care pool, or any successor thereto.

2961 (2) The total number of employees in the most recent fiscal year on whose behalf health care
2962 services were reimbursed in whole or in part by the uncompensated care pool, or any successor
2963 thereto, shall be calculated. In calculating this number, the authority shall use all resources
2964 available to enable it to determine the employment status of individuals for whom
2965 reimbursements were made, including quarterly wage reports maintained by the department of
2966 revenue.

2967 (3) The total number of employees as calculated in paragraph (2) shall be adjusted by
2968 multiplying that number by the percentage of employers in the commonwealth that are not
2969 contributing employers, as determined by the authority.

2970 (4) The total cost of liability associated with employees of non- contributing employers shall be
2971 determined by multiplying the number of employees, as calculated in paragraph (3) by the per-
2972 user share of private sector liability as calculated in paragraph (1).

2973 (5) The fair share employer contribution shall be calculated by dividing the total cost of liability
2974 as calculated in paragraph (4) by the total number of employees of employers that are not
2975 contributing employers, as determined by the authority.

2976 (6) The fair share employer contribution, as determined in paragraph (5) shall be adjusted
2977 annually to reflect medical inflation, using an appropriate index as determined by the authority.

2978 (7) The total dollar amount of health care services provided by physicians to non-elderly,
2979 uninsured residents of the commonwealth for which no reimbursement is made from the Health
2980 Safety Net Trust Fund shall be calculated using a survey of physicians or other data source that
2981 the authority determines is most accurate.

2982 (8) The per-employee cost of uncompensated physician care shall be calculated by dividing the
2983 dollar amount of such services, as calculated in paragraph (7) by the total number of employees
2984 of contributing employers in the commonwealth, as estimated by the authority using the most
2985 accurate data source available, as determined by the authority.

2986 (9) The annual fair share employer contribution shall be calculated by adding the fair share
2987 employer contribution as calculated in paragraph (6) and the per-employee cost of unreimbursed
2988 physician care, as calculated in paragraph (8).

2989 (10) Notwithstanding this section, the total annual fair share employer contribution shall not
2990 exceed $295 per employee which may be made in a single payment, or in equal amounts semi-
2991 annually or quarterly, at the employer's discretion.

2992 (d) The director of unemployment assistance shall determine quarterly each employer's liability
2993 for its fair share employer contribution. The director shall assess each employer liable for a fair

2994 share employer contribution in a quarter an amount based on 25 per cent of the annual fair share
2995 employer contribution rate applicable to that quarterly period and shall implement penalties for
2996 employers who fail to make contributions as required by this section. In order to reduce the
2997 administrative costs of collection of contributions, the director shall, to the extent possible, use
2998 any existing procedures implemented by the department of unemployment assistance to make
2999 similar collections. Amounts collected pursuant to this section shall be deposited in the
3000 Commonwealth Care Trust Fund, established by section 2OOO of chapter 29. Before depositing
3001 the amounts, the director may deduct all administrative costs incurred by the department of
3002 unemployment assistance as a result of this section, including an amount as determined by the
3003 United States Secretary of Labor in accordance with federal cost rules. Except where inconsistent
3004 with this section, the terms and conditions of chapter 151A which are applicable to the payment
3005 and collection of contributions shall apply to the same extent to the payment and collection of
3006 any obligation under this section. The department of unemployment assistance shall promulgate
3007 regulations necessary to implement this section.

3008 (e) In promulgating regulations defining the term "contribution" under this section, no proposed
3009 regulation by the authority, except an emergency regulation, shall take effect until 60 days after
3010 the proposed regulations have been transmitted to the joint committee on health care financing
3011 and the joint committee on financial services.

3012 SECTION 130A. Said subsection (c) of said section 188 of said chapter 149, as so amended, is
3013 hereby further amended by adding the following clause:-

3014 (11) In calculating the fair share assessment, employees who have qualifying health insurance
3015 coverage from a spouse, parent, veteran’s plan, or a plan due to disability or retirement shall not

3016 be included in the numerator or denominator for purposes of determining whether an employer is
3017 a contributing employer, as defined by the authority. The employer shall keep and maintain proof
3018 of their employee's insurance status, in a reasonable manner as defined by the authority.
3019
3020 SECTION 130B. Section 1 of Chapter 151A of the General Laws, as appearing, is hereby
3021 amended by striking out the definition of "Seasonal Employee" and inserting in place thereof the
3022 following:-

3023 "Seasonal Employee", shall mean any employee who:

3024 (1) Is employed by any employer, whether the employer is a seasonal employer as defined in
3025 Chapter 151A, Section 1 or any other employer, in seasonal employment during a regularly
3026 recurring period or period of up to sixteen consecutive weeks in a calendar year for all such
3027 seasonal periods, as determined by the director of unemployment assistance in consultation with
3028 the employer, and
3029 (2) Has been hired for a specific temporary seasonal period as determined by the director of
3030 unemployment assistance in consultation with the employer; and
3031 (3) Has been notified in writing at the time hired, or immediately following the seasonal
3032 determination by the department, whichever is later:
3033 (A) That the individual is performing services in seasonal employment for a specified
3034 season; and

3035 (B) That the individual's employment is limited to the beginning and ending dates of the
3036 employer's seasonal period as determined by the department in consultation with the employer.

3037 SECTION 131. Subsection (c) of section 46 of chapter 151A of the General Laws, as so
3038 appearing, is hereby amended by striking out paragraphs (7) and (8) and inserting in place
3039 thereof the following 2 paragraphs:—(7) to the division of health care finance and policy,
3040 information under an interagency agreement for the administration and enforcement of sections
3041 6B and 6C of chapter 118G.

3042 (8) to the commonwealth health insurance connector authority, information under an
3043 interagency agreement for the administration and enforcement of chapter 118H, the
3044 administration of the fair share employer contribution requirement under section 188 of chapter
3045 149 and the administration and enforcement of the free rider surcharge under section 17 of
3046 chapter 176Q.

3047 SECTION 132. Section 13 of chapter 152 of the General Laws, as so appearing, is hereby
3048 amended by striking out, in line 3, the words "finance and policy" and inserting in place thereof
3049 the following words:— cost and quality.

3050 SECTION 133. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby
3051 amended by adding the following definition:—

3052 "Wellness program", a wellness program receiving a seal of approval under section 206A of
3053 chapter 111.

3054 SECTION 134. Section 108 of said chapter 175 , as so appearing, is hereby amended by adding
3055 the following clause:—

3056 13. Any policy of accident and sickness shall include a premium rate adjustment based on
3057 employee participation in an approved wellness program.

3058 SECTION 135. Said chapter 175 is hereby further amended by inserting after section 108J the
3059 following 3 sections:-

3060 Section 108K. Pursuant to section 51 of chapter 118G, not later than January 1, 2014, carriers
3061 shall provide a toll-free number and website that enables consumers to request and obtain from
3062 the carrier in real time the maximum estimated amount the insured shall be responsible to pay for
3063 a proposed admission, procedure or service that is a medically necessary covered benefit, based
3064 on the information available to the carrier at the time the request is made, including any
3065 copayment, deductible, coinsurance or other out of pocket amount for any health care benefits;
3066 and a consumer disclosure alerting the insured that these are estimated costs, and that the actual
3067 amount the insured will be responsible to pay for a proposed admission, procedure or service
3068 may vary.

3069 Section 108L. Carriers that offer any policy of accident and sickness insurance or any general or
3070 blanket policy of insurance shall attribute every policyholder to a primary care provider.

3071 Section 108M. Pursuant to section 51 of chapter 118G, carriers shall disclose patient-level data
3072 including, but not limited to, health care service utilization, medical expenses, demographics,
3073 and where services are being provided, to all providers in their network, provided that data shall
3074 be limited to patients treated by that provider, so as to aid providers in managing the care of their
3075 own patient panel.

3076 SECTION 136. Said chapter 175 is hereby further amended by adding the following 4
3077 sections:-

3078 Section 226. As used in this section, the following words shall have the following meanings:

3079 “Self-insured group,” a self-insured or self-funded employer group health plan.

3080 “Third-party administrator,” an entity that administers payments for health care services on
3081 behalf of a client plan in exchange for an administrative fee.

3082 Pursuant to section 51 of chapter 118G, every third-party administrator shall disclose to their
3083 self-insured group clients contracted prices and quality of services of in-network providers.

3084 Section 227. (a) A payer or any entity acting for a payer under contract, when requiring prior
3085 authorization for a health care service or benefit, shall use and accept only the prior authorization
3086 forms designated for the specific types of services and benefits developed pursuant to subsection
3087 (c).

3088 (b) If a payer or any entity acting for a payer under contract fails to use or accept the required
3089 prior authorization form, or fails to respond within 2 business days after receiving a completed
3090 prior authorization request from a provider, pursuant to the submission of the prior authorization
3091 form developed as described in subsection (c), the prior authorization request shall be deemed to
3092 have been granted.

3093 (c) The commissioner shall develop and implement uniform prior authorization forms for
3094 different health care services and benefits by July 1, 2014. The forms shall cover such health care
3095 services and benefits including, but not limited to: provider office visits, prescription drug
3096 benefits, imaging and other diagnostic testing, laboratory testing and any other health care
3097 services. The commissioner shall develop forms for different kinds of services as it deems
3098 necessary or appropriate; provided, however, that all payers and any entities acting for a payer
3099 under contract shall use the uniform form designated by the commissioner for the specific type
3100 of service. Six months after the full set of forms is developed, every provider shall use the

3101 appropriate uniform prior authorization form to request prior authorization for coverage of the
3102 health care service or benefit and every payer or any entity acting for a payer under contract shall
3103 accept the form as sufficient to request prior authorization for the health care service or benefit.

3104 Nothing in this section will prohibit a payer or any entity acting for a payer under contract from
3105 using a prior authorization methodology that utilizes an internet webpage, internet webpage
3106 portal, or similar electronic, internet, and web-based system in lieu of a paper form, developed
3107 pursuant to subsection (c).

3108 (d) The prior authorization forms developed pursuant to subsection (c) shall meet the following
3109 criteria:

3110 (1) the forms shall not exceed 2 pages;

3111 (2) the forms shall be made electronically available;

3112 (3) the payer must be able to electronically accept the completed forms;

3113 (4) the commissioner, in developing the forms, shall seek input from interested stakeholders;

3114 (5) the commissioner shall ensure that the forms are consistent with existing prior authorization
3115 forms established by the federal Centers for Medicare and Medicaid Services; and

3116 (6) the commissioner, in developing the forms, shall consider other national standards pertaining
3117 to electronic prior authorization.

3118 7.) The forms shall allow the incorporation of personalized medicine, diagnostic information,
3119 and where relevant, personalized genomic, metabolic, cellular and anatomic data.

3120 (e) Nothing in this section shall limit a health plan from requiring prior authorization for
3121 services.

3122 Section 228. The commissioner shall establish standardized processes and procedures applicable
3123 to all health care providers and payers for the determination of a patient's health benefit plan
3124 eligibility at or prior to the time of service. As part of such processes and procedures, the
3125 commissioner shall (i) require payers to implement automated approval systems such as decision
3126 support software in place of telephone approvals for specific types of services specified by the
3127 commissioner and (ii) require establishment of an electronic data exchange to allow providers to
3128 determine eligibility at or prior to the point of care.

3129 Section 229 The commissioner shall develop a summary of payments form to be used by all
3130 health care payers in the commonwealth that is provided to health care consumers with respect to
3131 provider claims submitted to a payer and written in an easily readable and understandable format
3132 showing the consumer's responsibility, if any, for payment of any portion of a health care
3133 provider claim. The summary of payments form shall include the following information: (i)
3134 provider charges; (ii) contracted rate or allowed amount; (iii) benefits provided by the payer; (iv)
3135 the consumer's co-payment; (v) the amount applied to a deductible; and (vi) any other amount
3136 not covered by the payer for which the consumer is responsible, including co-insurance. The
3137 commissioner shall promulgate regulations to implement the requirements of this section no later
3138 than July 1, 2014.

3139 SECTION 137. Section 5 of chapter 176A of the General Laws, as appearing in the 2010
3140 Official Edition, is hereby amended by striking out, in line 35, the words "finance and policy"
3141 and inserting in place thereof the following words:—cost and quality.

3142 SECTION 138. Section 17 of said chapter 176A, as so appearing, is hereby amended by striking
3143 out, in lines 4 and 10, the words “finance and policy” and inserting in place thereof, in each
3144 instance, the following words:—cost and quality.

3145 SECTION 139. Said chapter 176A is hereby further amended by adding the following 3
3146 sections:—

3147 Section 35. Pursuant to section 51 of chapter 118G every non-profit hospital service corporation
3148 shall provide a toll-free number and website that enables consumers to request and obtain from
3149 the corporation in real time the maximum estimated amount the subscriber will be responsible to
3150 pay for a proposed admission, procedure or service that is a medically necessary covered benefit,
3151 based on the information available to the corporation at the time the request is made, including
3152 any copayment, deductible, coinsurance or other out of pocket amount for any health care
3153 benefits; and a consumer disclosure alerting the subscriber that these are estimated costs, and that
3154 the actual amount the subscriber shall be responsible to pay for a proposed admission, procedure
3155 or service may vary.

3156 Section 36. Every non-profit hospital service corporation shall attribute every subscriber to a
3157 primary care provider.

3158 Section 37. Pursuant to section 51 of chapter 118G, every non-profit hospital service corporation
3159 shall disclose patient-level data including, but not limited to, health care service utilization,
3160 medical expenses, demographics, and where services are being provided, to all providers in their
3161 network, provided that data shall be limited to patients treated by that provider, so as to aid
3162 providers in managing the care of their own patient panel.

3163 SECTION 140. Chapter 176B of the General Laws is hereby amended by adding the following
3164 3 sections:-

3165 Section 23. Pursuant to section 51 of chapter 118G, every medical service corporation shall
3166 provide a toll-free number and website that enables consumers to request and obtain from the
3167 corporation in real time the maximum estimated amount the subscriber shall be responsible to
3168 pay for a proposed admission, procedure or service that is a medically necessary covered benefit,
3169 based on the information available to the corporation at the time the request is made, including
3170 any copayment, deductible, coinsurance or other out of pocket amount for any health care
3171 benefits; and a consumer disclosure alerting the subscriber that these are estimated costs, and that
3172 the actual amount the subscriber will be responsible to pay for a proposed admission, procedure
3173 or service may vary.

3174 Section 24. Every medical service corporation shall attribute every subscriber to a primary care
3175 provider.

3176 Section 25. Pursuant to section 51 of chapter 118G, every medical service corporation shall
3177 disclose patient-level data including, but not limited to, health care service utilization, medical
3178 expenses, demographics, and where services are being provided, to all providers in their
3179 network, provided that data shall be limited to patients treated by that provider, so as to aid
3180 providers in managing the care of their own patient panel.

3181 SECTION 141. Chapter 176G of the General Lawsis hereby amended by adding the following
3182 3 sections:—

3183 Section 31. Pursuant to section 51 of chapter 118G, every health maintenance organization shall
3184 provide a toll-free number and website that enables consumers to request and obtain from the

3185 health maintenance organization in real time the maximum estimated amount the member shall
3186 be responsible to pay for a proposed admission, procedure or service that is a medically
3187 necessary covered benefit, based on the information available to the health maintenance
3188 organization at the time the request is made, including any copayment, deductible, coinsurance
3189 or other out of pocket amount for any health care benefits; and a consumer disclosure alerting the
3190 member that these are estimated costs, and that the actual amount the member will be
3191 responsible to pay for a proposed admission, procedure or service may vary.

3192 Section 32. Every health maintenance organization shall attribute every member to a primary
3193 care provider.

3194 Section 33. Pursuant to section 51 of chapter 118G, every health maintenance organization shall
3195 disclose patient-level data including, but not limited to, health care service utilization, medical
3196 expenses, demographics, and where services are being provided, to all providers in their
3197 network, provided that data shall be limited to patients treated by that provider, so as to aid
3198 providers in managing the care of their own patient panel.

3199 SECTION 142. Section 3 of chapter 176J of the General Laws, as appearing in the 2010 Official
3200 Edition, is hereby amended by striking out, in line 59, the word "may" and inserting in place
3201 thereof the following word:— shall.

3202 SECTION 143. Section 4 of said chapter 176J, as so appearing, is hereby amended by striking
3203 out, in lines 66 and 67, the words "section 217 of chapter 111" and inserting in place thereof the
3204 following words:—section 65 of chapter 118G.

3205 SECTION 143A. Subsection (b) of section 6 of Chapter 176J of the General laws, as so
3206 appearing in the 2010 Official Edition, is hereby amended by adding the following subsection:-

3207 (xi) For purposes of this section, medical loss ratios shall not include fees on commissions
3208 included in premiums that are collected solely for the purpose of passing such fees or
3209 commissions on to insurance agents or brokers to the extent such fees or commissions are
3210 actually paid.

3211 SECTION 144. Section 11 of said chapter 176J, as so appearing, is hereby amended by
3212 insertingafter the word “providers” , in line 60, the following words:—, smart tiering plan in
3213 which health services are tiered and member cost sharing is based on the tier placement of the
3214 services,.

3215 SECTION 147. The first paragraph of subsection (b) of said section 11 of said chapter 176J, as
3216 so appearing, is hereby amended by adding the following 2 sentences:— Smart tiering plans
3217 may take into account the number of services performed each year by the provider. For smart
3218 tiering plans, if a medically necessary and covered service is available at no more than 5
3219 facilities in the state, as determined by the division of health care cost and quality, that service
3220 shall not be placed into the most expensive cost-sharing tier.

3221 SECTION 148 Said section 11 of said chapter 176J, as so appearing, is hereby further amended
3222 by adding the following 3 subsections:—

3223 (h) A smart tiering plan shall be a tiering product, which offers a cost-sharing differential based
3224 on services rather than facilities providing services. A service covered in a smart tiering plan
3225 may be reimbursed through bundled payments for acute and chronic diseases.

3226 (i) The division shall review smart tiering plans in a manner consistent with other products
3227 offered in the commonwealth. The division may disapprove a smart tiering plan if it determines
3228 that the carrier differentiated cost-sharing obligations solely based on the provider. There shall be

3229 a rebuttable presumption that a plan has violated this subsection if the cost-sharing obligation for
3230 all services provided by a provider, including a health care facility, accountable care
3231 organization, patient centered medical home, or provider organization, is the same.

3232 (j) The commissioner when reviewing smart tiering plans shall promote the following goals: (1)
3233 avoid creating consumer confusion; (2) minimize the administrative burdens on payers and
3234 providers in implementing smart tiering plans; and (3) allow patients to get their services in the
3235 proper locations.

3236 SECTION 145. Said section 11 of said chapter 176J, as so appearing, is hereby amended by
3237 striking out, in line 64, the figure "12" and inserting in place thereof the following figure:—16.

3238 Section 146. Said section 11 of chapter 176J of the General Laws, as so appearing, is hereby
3239 further amended by inserting the following 2 sentences at the end of subsection (a):- "The
3240 division of insurance shall determine the base rate discount on an annual basis. The division of
3241 insurance may apply a waiver process from the rate discount under this section to carriers who
3242 receive 80 per cent or more of their incomes from government programs or which have service
3243 areas which do not include either Suffolk or Middlesex Counties and who were first admitted to
3244 do business by the division of insurance on or before January 1, 1988, as health maintenance
3245 organizations under chapter 176G.

3246 SECTION 149. Section 12 of said chapter 176J as so appearing, is hereby amended by striking
3247 out, in line 60, the words "finance and policy" and inserting in place thereof the following
3248 words:—cost and quality.

3249 SECTION 150. Said chapter 176J is hereby further amended by adding the following 3
3250 sections:-

3251 Section 16. Pursuant to section 51 of chapter 118G,carriers shall provide a toll-free number and
3252 website that enables consumers to request and obtain from the carrier in real time the maximum
3253 estimated amount the member shall be responsible to pay for a proposed admission, procedure or
3254 service that is a medically necessary covered benefit, based on the information available to the
3255 carrier at the time the request is made, including any copayment, deductible, coinsurance or other
3256 out of pocket amount for any health care benefits; and a consumer disclosure alerting the
3257 member that these are estimated costs, and that the actual amount the member will be
3258 responsible to pay for a proposed admission, procedure or service may vary.

3259 Section 17. Carriers shall attribute every member to a primary care provider.

3260 Section 18. Pursuant to section 51 of chapter 118G, every carrier shall disclose patient-level data
3261 including, but not limited to, health care service utilization, medical expenses, demographics,
3262 and where services are being provided, to all providers in their network, provided that data shall
3263 be limited to patients treated by that provider, so as to aid providers in managing the care of their
3264 own patient panel.

3265 SECTION 151. Section 5 of chapter 176M of the General Laws, as appearing in the 2010
3266 Official Edition, is hereby amended by striking out, in lines 95 and 100, the words “finance and
3267 policy” and inserting in place thereof, in each instance, the following words:—cost and quality.

3268 SECTION 152. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby
3269 amended by inserting before the definition of “Adverse determination” the following definition:-

3270 “Accountable care organization”, an accountable care organization as defined in chapter 118J.

3271 SECTION 153. Said section 1 of said chapter 176O , as so appearing, is hereby further amended
3272 by inserting after the definition of "Adverse determination" the following definition:—

3273 "Allowed amount", the contractually agreed upon amount paid by a carrier to a health care
3274 provider for health care services.

3275 SECTION 154. Said section 1 of said chapter 176O, as so appearing, is hereby further amended
3276 by inserting after the definition of "Emergency medical condition" the following definition:-

3277 "Executive director", the executive director of the division of health care cost and quality.

3278 SECTION 157 Said section 1 of said chapter 176O ,aso so appearing, is hereby further amended
3279 by inserting after the definition of "Participating provider" the following definition:-

3280 "Patient centered medical home", a patient centered medical home as defined in section 45 of
3281 118G.

3282 SECTION 155. Said section 1 of said chapter 176O, as so appearing, is hereby further amended
3283 by inserting after the definition of "Health care services" the following definition:—

3284 "Hospital-based physician", a pathologist, anesthesiologist, radiologist or emergency room
3285 physician who practices exclusively within the inpatient or outpatient hospital setting and who
3286 provides health care services to a carrier's insured only as a result of the insured being directed
3287 to the hospital inpatient or outpatient setting. This definition may be expanded, after consultation
3288 with a statewide advisory committee composed of an equal number of organizations representing
3289 providers and those representing health plans, including, but not limited to, a representative from
3290 the Massachusetts Medical Society, the Massachusetts Hospital Association, the Massachusetts
3291 Association of Health Plans, the Massachusetts Association of Medical Staff Services, and Blue

3292 Cross Blue Shield of Massachusetts, by regulation to include additional categories of physicians
3293 who practice exclusively within the inpatient or outpatient hospital setting and who provide
3294 health care services to a carrier's insured only as a result of the insured being directed to the
3295 hospital inpatient or outpatient setting.

3296 SECTION 156. Said section 1 of said chapter 176O, as so appearing, is hereby further amended
3297 by striking out the definition of "Office of patient protection" and inserting in place thereof the
3298 following definition:—

3299 "Office of patient protection", the office in the division of health care cost and quality
3300 established by section 63 of chapter 118G, responsible for the administration and enforcement of
3301 sections 13, 14, 15 and 16.

3302 SECTION 158. Said section 1 of said chapter 176O, as so appearing, is hereby further amended
3303 by inserting after the definition of "Person" the following definition:-

3304 "Primary care provider", a health care professional qualified to provide general medical care for
3305 common health care problems who: (1) supervises, coordinates, prescribes, or otherwise provides
3306 or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains
3307 continuity of care within the scope of practice.

3308 SECTION159. Said section 1 of said chapter 176O, as so appearing, is hereby further amended
3309 by inserting after the definition of "Prospective review" the following definition:-

3310 "Physician organization", a physician organization as defined in section 53H of chapter 111.

3311 SECTION 160. Section 2 of said chapter 176O, as so appearing, is hereby amended by striking
3312 out, in lines 22 and 23, the words “finance and policy” and inserting in place thereof the
3313 following words:— cost and quality.

3314 SECTION 161. Said section 2 of said chapter 176O, as so appearing, is hereby further amended
3315 by striking out subsection (c) and inserting in place thereof the following subsection:—

3316 (c) Regulations promulgated by the bureau shall be consistent with and not duplicate or overlap
3317 with the regulations promulgated by the office of patient protection in the division of health care
3318 cost and quality established by section 63 of chapter 118G.

3319 SECTION 162. Said chapter 176O is hereby further amended by inserting after section 2 the
3320 following 2 sections:—

3321 Section 2A. (a) The bureau shall adopt a common application for initial credentialing or
3322 appointment and a common application for re-credentialing or reappointment. The bureau, after
3323 consultation with a statewide advisory committee composed of an equal number of organizations
3324 representing providers and those representing health plans, including, but not limited to, a
3325 representative from the Massachusetts Medical Society, the Massachusetts Hospital Association,
3326 the Massachusetts Association of Health Plans, the Massachusetts Association of Medical Staff
3327 Services, and Blue Cross Blue Shield of Massachusetts, a representative of the board of
3328 registration in medicine, a representative of the board of registration in nursing and a
3329 representative of the department of public health, shall adopt and make any revisions to the
3330 common credentialing application forms that includes, but is not limited to, applicable
3331 accreditation as well as federal and state regulatory changes that will impact such forms. Such
3332 forms shall not be applicable in those instances where the carrier has both delegated

3333 credentialing to a provider organization and does not require submission of a credentialing
3334 application.

3335 (b) A carrier and a participating provider shall not use any initial physician credentialing
3336 application form other than the uniform initial physician application form or a uniform electronic
3337 version of said form. A carrier and a participating provider shall not use any physician re-
3338 credentialing application form other than the uniform physician re-credentialing application form
3339 or a uniform electronic version of said form. A carrier may require that a physician profile be
3340 submitted in addition to the uniform physician re-credentialing application form.

3341 (c) A carrier shall act upon and complete the credentialing process for 95 per cent of complete
3342 initial physician credentialing applications submitted by or on behalf of a physician applicant
3343 within 30 calendar days of receipt of a complete application. An application shall be considered
3344 complete if it contains all of the following elements submitted by the physician applicant or
3345 designee or obtained by the carrier from a credentials verification organization certified by the
3346 National Committee for Quality Assurance: —

3347 (i) the application form is signed and appropriately dated by the physician applicant;

3348 (ii) all information on the application is submitted in a legible and complete manner and any
3349 affirmative answers are accompanied by explanations satisfactory to the carrier;

3350 (iii) a current curriculum vitae with appropriate required dates;

3351 (iv) a signed, currently dated applicant's authorization to release information form;

3352 (v) copies of the applicant's current licenses in all states in which the physician practices;

3353 (vi) a copy of the applicant's current Massachusetts controlled substances registration and a
3354 copy of the applicant's current federal DEA controlled substance certificate or, if not available, a
3355 letter describing prescribing arrangements;

3356 (vii) a copy of the applicant's current malpractice face sheet coverage statement including
3357 amounts and dates of coverage;

3358 (viii) hospital letter or verification of hospital privileges or alternate pathways;

3359 (ix) documentation of board certification or alternate pathways;

3360 (x) documentation of training, if not board certified;

3361 (xi) there are no affirmative responses on questions related to quality or clinical competence;

3362 (xii) there are no modifications to the applicant's authorization to release information form;

3363 (xiii) there are no discrepancies between the information submitted by or on behalf of the
3364 physician and information received from other sources; and

3365 (xiv) the appropriate health plan participation agreement, if applicable.

3366 (d) A carrier shall report to a physician applicant or designee the status of a submitted initial
3367 credentialing application within a reasonable timeframe. Said report shall include, but not be
3368 limited to, the application receipt date and, if incomplete, an itemization of all missing or
3369 incomplete items. A carrier may return an incomplete application to the submitter. A physician
3370 applicant or designee shall be responsible for any and all missing or incomplete items.

3371 (e) A carrier shall notify a physician applicant of the carrier's credentialing committee's decision
3372 on an initial credentialing application within 4 business days of the decision. Said notice shall
3373 include the committee's decision and the decision date.

3374 (f) A physician, other than a primary care provider compensated on a capitated basis, who has
3375 been credentialed pursuant to the terms of this section shall be allowed to treat a carrier's
3376 insureds and shall be reimbursed by the carrier for covered services provided to a carrier's
3377 insureds effective as of the carrier's credentialing committee's decision date. A primary care
3378 physician compensated on a capitated basis who has been credentialed pursuant to the terms
3379 established in this section shall be allowed to treat a carrier's insureds and shall be reimbursed by
3380 the carrier for covered services provided to the carrier's insureds effective no later than the first
3381 day of the month following the carrier's credentialing committee's decision date.

3382 (g) This section shall not apply to the credentialing and re-credentialing by carriers of
3383 psychiatrists or hospital-based physicians.

3384 Section 2B. (a) The bureau's accreditation requirements related to credentialing and re-
3385 credentialing shall not require a carrier to complete the credentialing or re-credentialing process
3386 for hospital-based physicians.

3387 (b) Except as provided in paragraph (d), a carrier shall not require a hospital-based physician to
3388 complete the credentialing and re-credentialing process established pursuant to the bureau's
3389 accreditation requirements.

3390 (c) A carrier may establish an abbreviated data submission process for hospital-based
3391 physicians. Except as provided in paragraph (d) of this section, said process shall be limited to a

3392 review of the data elements required to be collected and reviewed pursuant to applicable federal
3393 and state regulations as well as national accreditation organization standards.

3394 (d) In the event that the carrier determines that there is a need to further review a hospital-based
3395 physician's credentials due to quality of care concerns, complaints from insureds, applicable law
3396 or other good faith concerns, the carrier may conduct such review as is necessary to make a
3397 credentialing or re-credentialing decision.

3398 (e) Nothing in this section shall be construed to prohibit a carrier from requiring a physician to
3399 submit information or taking other actions necessary for the carrier to comply with the applicable
3400 regulations of the board of registration in medicine.

3401 (f) The bureau, after consultation with a statewide advisory committee composed of an equal
3402 number of organizations representing providers and those representing health plans including but
3403 not limited to a representative from the Massachusetts Hospital Association, the Massachusetts
3404 Medical Society, the Massachusetts Association of Health Plans, the Massachusetts Association
3405 of Medical Staff Services, and Blue Cross and Blue Shield of Massachusetts, a representative of
3406 the board of registration in medicine, a representative of the board of registration in nursing and
3407 a representative of the department of public health, shall develop standard criteria and oversight
3408 guidelines that may be used by carriers to delegate the credentialing function to providers. Such
3409 criteria and oversight guidelines shall meet applicable accreditation standards.

3410 SECTION 163. Section 5B of said chapter 176O, as appearing in the 2010 Official Edition, is
3411 hereby amended by striking out, in line12, the words "finance and policy, the health care quality
3412 and cost council" and inserting in place thereof the following words:— cost and quality.

3413 SECTION 164. Subsection (a) of section 6 of said chapter 176O, as so appearing, is hereby
3414 amended by striking out clause (3) and inserting in place thereof the following clause:—

3415 (3) the limitations on the scope of health care services and any other benefits to be provided,
3416 including (i) all restrictions relating to preexisting condition exclusions, and (ii) an explanation
3417 of any facility fee, allowed amount, co-insurance, copayment, deductible, or other amount, that
3418 the insured may be responsible to pay to obtain covered benefits from network or out-of-network
3419 providers.

3420 SECTION 165. Said subsection (a) of said section 6 of said chapter 176O, as so appearing, is
3421 hereby further amended by striking outclause (13) and inserting in place thereof the following
3422 clause:—

3423 (13) a statement on how to obtain the report regarding grievances from the office of patient
3424 protection pursuant to paragraph (2) of subsection (a) of section 63 of chapter 118G;.

3425 SECTION 166. Section 7 of said chapter 176O, as so appearing, is hereby amended by striking
3426 out, in line 45, the words "department of public health" and inserting in place thereof the
3427 following:—division of health care cost and quality.

3428 SECTION 167. Section 9A of said chapter 176O, as so appearing, is hereby amended by adding
3429 the following 2 subsections:—

3430 (d) limits the ability of either the carrier or the health care provider from disclosing the allowed
3431 amount and fees of services to an insured or insured's treating health care provider.

3432 (e) limits the ability of either the carrier or the health care provider from disclosing out-of-pocket
3433 costs to an insured.

3434 SECTION 167A. Subsection (a) of section 12 of chapter 176O of the General Laws is hereby
3435 amended by adding at the end of the second paragraph the following:-
3436 "and made easily accessible and up-to-date on a carrier or utilization review organization's
3437 website to subscribers, health care providers and the general public. If a carrier or utilization
3438 review organization intends either to implement a new preauthorization requirement or
3439 restriction or amend an existing requirement or restriction, the carrier or utilization review
3440 organization shall ensure that the new or amended requirement or restriction shall not be
3441 implemented unless the carrier's or utilization review organization's website has been updated to
3442 reflect the new or amended requirement or restriction."

3443 SECTION 167B. Section 16 of chapter 176O of the General Laws is hereby amended by striking
3444 subsection (b) and inserting in place thereof the following subsection:-
3445 "(b) A carrier shall be required to pay for health care services ordered by a treating physician or
3446 primary care provider if: (1) the services are a covered benefit under the insured's health benefit
3447 plan; and (2) the services are medically necessary. A carrier may develop guidelines to be used
3448 in applying the standard of medical necessity, as defined in this subsection. Any such medical
3449 necessity guidelines utilized by a carrier in making coverage determinations shall be: (i)
3450 developed with input from practicing physicians and participating providers in the carrier's or
3451 utilization review organization's service area; (ii) developed under the standards adopted by
3452 national accreditation organizations; (iii) updated at least biennially or more often as new
3453 treatments, applications and technologies are adopted as generally accepted professional medical
3454 practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall
3455 consider the individual health care needs of the insured. Any such medical necessity guidelines
3456 criteria shall be applied consistently by a carrier or a utilization review organization and made

3457 easily accessible and up-to-date on a carrier or utilization review organization's website to
3458 subscribers, health care providers and the general public. If a carrier or utilization review
3459 organization intends either to implement a new medical necessity guideline or amend an existing
3460 requirement or restriction, the carrier or utilization review organization shall ensure that the new
3461 or amended requirement or restriction shall not be implemented unless the carrier's or utilization
3462 review organization's website has been updated to reflect the new or amended requirement or
3463 restriction."

3464 SECTION 168. Section 14 of said chapter 176O, as so appearing, is hereby amended by striking
3465 out, in line 6, the words "section 217 of chapter 111" and inserting in place thereof the following
3466 words:— section 63 of chapter 118G.

3467 SECTION 169. Said chapter 176O is hereby further amended by striking out section 15, as so
3468 appearing, and inserting in place thereof the following section:—

3469 Section 15. (a) A carrier that allows or requires the designation of a primary care provider shall
3470 notify an insured at least 30 days before the disenrollment of such insured's primary care
3471 provider and shall permit such insured to continue to be covered for health services, consistent
3472 with the terms of the evidence of coverage, by such primary care provider for at least 30 days
3473 after said provider is disenrolled, other than disenrollment for quality-related reasons or for
3474 fraud. Such notice shall also include a description of the procedure for choosing an alternative
3475 primary care provider.

3476 (b) A carrier shall allow any female insured who is in her second or third trimester of pregnancy
3477 and whose provider in connection with her pregnancy is involuntarily disenrolled, other than
3478 disenrollment for quality-related reasons or for fraud, to continue treatment with said provider,

3479 consistent with the terms of the evidence of coverage, for the period up to and including the
3480 insured's first postpartum visit.

3481 (c) A carrier shall allow any insured who is terminally ill and whose provider in connection with
3482 said illness is involuntarily disenrolled, other than disenrollment for quality-related reasons or for
3483 fraud, to continue treatment with said provider, consistent with the terms of the evidence of
3484 coverage, until the insured's death.

3485 (d) A carrier shall provide coverage for health services for up to 30 days from the effective date
3486 of coverage to a new insured by a physician who is not a participating provider in the carrier's
3487 network if: (1) the insured's employer only offers the insured a choice of carriers in which said
3488 physician is not a participating provider, and (2) said physician is providing the insured with an
3489 ongoing course of treatment or is the insured's primary care provider. With respect to an insured
3490 in her second or third trimester of pregnancy, this provision shall apply to services rendered
3491 through the first postpartum visit. With respect to an insured with a terminal illness, this
3492 provision shall apply to services rendered until death.

3493 (e) A carrier may condition coverage of continued treatment by a provider under subsections (a)
3494 to (d), inclusive, upon the provider's agreeing: (1) to accept reimbursement from the carrier at the
3495 rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing
3496 with respect to the insured in an amount that would exceed the cost sharing that could have been
3497 imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards
3498 of the carrier and to provide the carrier with necessary medical information related to the care
3499 provided; and (3) to adhere to such carrier's policies and procedures, including procedures
3500 regarding referrals, obtaining prior authorization and providing services pursuant to a treatment

3501 plan, if any, approved by the carrier. Nothing in this subsection shall be construed to require the
3502 coverage of benefits that would not have been covered if the provider involved remained a
3503 participating provider.

3504 (f) A carrier that requires an insured to designate a primary care provider shall allow such a
3505 primary care provider to authorize a standing referral for specialty health care provided by a
3506 health care provider participating in such carrier's network when (1) the primary care provider
3507 determines that such referrals are appropriate, (2) the provider of specialty health care agrees to a
3508 treatment plan for the insured and provides the primary care provider with all necessary clinical
3509 and administrative information on a regular basis, and (3) the health care services to be provided
3510 are consistent with the terms of the evidence of coverage. Nothing in this section shall be
3511 construed to permit a provider of specialty health care who is the subject of a referral to
3512 authorize any further referral of an insured to any other provider without the approval of the
3513 insured's carrier.

3514 (g) No carrier shall require an insured to obtain a referral or prior authorization from a primary
3515 care provider for the following specialty care provided by an obstetrician, gynecologist, certified
3516 nurse-midwife or family practitioner participating in such carrier's health care provider network:
3517 (1) annual preventive gynecologic health examinations, including any subsequent obstetric or
3518 gynecological services determined by such obstetrician, gynecologist, certified nurse-midwife or
3519 family practitioner to be medically necessary as a result of such examination; (2) maternity care;
3520 and (3) medically necessary evaluations and resultant health care services for acute or emergency
3521 gynecological conditions. No carrier shall require higher copayments, coinsurance, deductibles
3522 or additional cost sharing arrangements for such services provided to such insureds in the
3523 absence of a referral from a primary care provider. Carriers may establish reasonable

3524 requirements for participating obstetricians, gynecologists, certified nurse-midwives or family
3525 practitioners to communicate with an insured's primary care provider regarding the insured's
3526 condition, treatment, and need for follow-up care. Nothing in this section shall be construed to
3527 permit an obstetrician, gynecologist, certified nurse-midwife or family practitioner to authorize
3528 any further referral of an insured to any other provider without the approval of the insured's
3529 carrier.

3530 (h) A carrier shall provide coverage of pediatric specialty care, including mental health care, by
3531 persons with recognized expertise in specialty pediatrics to insureds requiring such services.

3532 (i) A carrier, including a dental or vision carrier, shall provide health, dental or vision care
3533 providers applying to be participating providers who are denied such status with a written reason
3534 or reasons for denial of such application.

3535 (j) No carrier shall make a contract with a health care provider which includes a provision
3536 permitting termination without cause. A carrier shall provide a written statement to a provider of
3537 the reason or reasons for such provider's involuntary disenrollment.

3538 (k) A carrier, including a dental or vision carrier, shall provide insureds, upon request, interpreter
3539 and translation services related to administrative procedures.

3540 SECTION 170. Subsection (a) of section 20 of said chapter 176O, as appearing in the 2010
3541 Official Edition, is hereby amended by striking outclause (3) and inserting in place thereof the
3542 following clause:—

3543 (3) a statement that the office of patient protection, established by section 65 of chapter 118G, is
3544 available to assist consumers, a description of the grievance and review processes available to

3545 consumers under this chapter, and relevant contact information to access the office and these
3546 processes.

3547 SECTION 171. Section 21 of said chapter 176O, as so appearing, is hereby amended by
3548 striking out, in line 109, the words “finance and policy” and inserting in place thereof the
3549 following words:—cost and quality.

3550 SECTION 172. Said chapter 176O is hereby further amended by adding the following 2
3551 sections:-

3552 Section 22. (a) Accountable care organizations, patient centered medical homes, or physician
3553 organizations who are paid through an alternative payment methodology with shared risk shall
3554 create internal appeals processes that are consistent with the appeal procedures of sections 12
3555 through 14 of chapter 176O. The processes shall be available to the public in both written format
3556 and available by request in electronic format.

3557 (b) The internal appeals processes in subsection (a) shall: (1) be completed in a period no longer
3558 than 14 days; provided, however, that an expedited internal appeal shall be completed in a period
3559 no longer that 3 days for a patient with an urgent medical need; and (2) offer an independent
3560 external opinion.

3561 (c) Accountable care organizations and patient centered medical homes, with an approval from
3562 the executive director, shall designate an independent third party as an ombudsman. Said
3563 ombudsman shall act as an advocate for patients; provided that any patient may elect any person,
3564 including, but not limited to, a spouse or other family member, an attorney of record or a legal
3565 guardian, to act as their patient advocate or independent care coordinator.

3566 (d) The executive director shall promulgate regulations necessary to implement this section.

3567 Section 23. (a) Accountable care organizations, patient centered medical homes, or physician
3568 organizations who are paid through an alternative payment methodology with shared risk shall
3569 provide an external second opinion. The external second opinion shall be conducted by a
3570 provider who is not a member of the global payment risk sharing arrangement.

3571 SECTION 173. Section 1 of chapter 176Q of the General Laws, as so appearing, is hereby
3572 amended by striking out, in line 23, the words "finance and policy" and inserting in place thereof
3573 the following words:—cost and quality.

3574 SECTION 174. Said chapter 176Q is hereby further amended by adding the following
3575 section:—

3576 Section 17. (a) The authority shall, upon verification of the provision of services and costs to a
3577 state-funded employee, assess a free rider surcharge on the non-providing employer under
3578 regulations promulgated by the authority.

3579 (b) The amount of the free rider surcharge on non-providing employers shall be determined by
3580 the authority under regulations promulgated by the authority, and assessed by the authority not
3581 later than 3 months after the end of each hospital fiscal year, with payment by non-providing
3582 employers not later than 180 days after the assessment. The amount charged by the authority
3583 shall be greater than 10 per cent but no greater than 100 per cent of the cost to the state of the
3584 services provided to the state-funded employee, considering all payments received by the state
3585 from other financing sources for free care; provided that the "cost to the state" for services
3586 provided to any state-funded employee may be determined by the authority as a percentage of
3587 the state's share of aggregate costs for health services. The free rider surcharge shall only be

3588 triggered upon incurring $50,000 or more, in any hospital fiscal year, in free care services for
3589 any employer's employees, or dependents of such persons, in aggregate, regardless of how many
3590 state-funded employees are employed by that employer.

3591 (c) The formula for assessing free rider surcharges on non-providing employers shall be set forth
3592 in regulations promulgated by the authority that shall be based on factors including, but not
3593 limited to: (i) the number of incidents during the past year in which employees of the non-
3594 providing employer received services reimbursed by the health safety net office under section
3595 39; (ii) the number of persons employed by the non-providing employer; (iii) the proportion of
3596 employees for whom the non-providing employer provides health insurance.

3597 (d) If a state-funded employee is employed by more than 1 non-providing employer at the time
3598 he or she receives services, the authority shall assess a free rider surcharge on each said
3599 employer consistent with the formula established by the authority under this section.

3600 (e) The authority shall specify by regulation appropriate mechanisms for implementing free rider
3601 surcharges on non-providing employers. Said regulations shall include, but not be limited to, the
3602 following provisions:—

3603 (i) appropriate mechanisms that provide for determination and payment of surcharge by a non-
3604 providing employer including requirements for data to be submitted by employers, employees,
3605 acute hospitals and ambulatory surgical centers, and other persons; and

3606 (ii) penalties for nonpayment or late payment by the non-providing employer, including
3607 assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of
3608 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.

3609 (f) All surcharge payments made under this section shall be deposited into the Commonwealth
3610 Care Trust Fund, established pursuant to section 2OOO of chapter 29.

3611 (g) A non-providing employer's liability to that fund shall in the case of a transfer of ownership
3612 be assumed by the successor in interest to the non-providing employer's.

3613 (h) If a non-providing employer fails to file any data, statistics or schedules or other information
3614 required under this chapter or by any regulation promulgated by the authority, the authority shall
3615 provide written notice of the required information. If the employer fails to provide information
3616 within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject to a civil
3617 penalty of not more than $5,000 for each week on which such violation occurs or continues,
3618 which penalty may be assessed in an action brought on behalf of the commonwealth in any court
3619 of competent jurisdiction.

3620 (i) The attorney general shall bring any appropriate action, including injunctive relief, as may be
3621 necessary for the enforcement of this chapter.

3622 (j) No employer shall discriminate against any employee on the basis of the employee's receipt
3623 of free care, the employee's reporting or disclosure of his or her employer's identity and other
3624 information about the employer, the employee's completion of a Health Insurance Responsibility
3625 Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed
3626 against the employer in relation to the employee. Violation of this subsection shall constitute a
3627 per se violation of chapter 93A.

3628 (k) A hospital, surgical center, health center or other entity that provides uncompensated care
3629 pool services shall provide an uninsured patient with written notice of the criminal penalties for
3630 committing fraud in connection with the receipt of uncompensated care pool services. The

3631 authority shall promulgate a standard written notice form to be made available to health care
3632 providers in English and foreign languages. The form shall further include written notice of
3633 every employee's protection from employment discrimination under this section.

3634 SECTION 175. The General Laws are hereby amended by inserting after chapter 176R the
3635 following chapter:-

3636 CHAPTER 176S

3637 CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

3638 Section 1. As used in this chapter, the following words shall, unless the context clearly requires
3639 otherwise, have the following meanings:-

3640 "Carrier", (1) an insurer licensed or otherwise authorized to transact accident or health insurance
3641 under chapter 175; (2) a nonprofit hospital service corporation organized under chapter 176A;
3642 (3) a nonprofit medical service corporation organized under chapter 176B; (4) a health
3643 maintenance organization organized under chapter 176G; (5) an organization entering into a
3644 preferred provider arrangement under chapter 176I; (6) a contributory group general or blanket
3645 insurance for persons in the service of the commonwealth under chapter 32A; (7) a contributory
3646 group general or blanket insurance for persons in the service of counties, cities, towns and
3647 districts, and their dependents under chapter 32B; (8) the medical assistance program
3648 administered by the division of medical assistance pursuant to chapter 118E and in accordance
3649 with Title XIX of the Social Security Act or any successor statute; and (9) any other medical
3650 assistance program operated by a governmental unit for persons categorically eligible for such
3651 program.

3652 “Commissioner”, the commissioner of insurance.

3653 “Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.

3654 “Nondiscriminatory basis”, a carrier shall be deemed to be providing coverage on a non-
3655 discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service
3656 limitation imposed on coverage for the care provided by a physician assistant which is less than
3657 any annual or lifetime dollar or unit of service limitation imposed on coverage for the same
3658 services by other participating providers.

3659 “Participating provider’, a provider who, under terms and conditions of a contract with the
3660 carrier or with its contractor or subcontractor, has agreed to provide health care services to an
3661 insured with an expectation of receiving payment, other than coinsurance, co-payments or
3662 deductibles, directly or indirectly from the carrier.

3663 “Physician assistant”, a person who is a graduate of an approved program for the training of
3664 physician assistants who is supervised by a registered physician in accordance with sections 9C
3665 to 9H, inclusive, of chapter 112, and who has passed the Physician Assistant National Certifying
3666 Exam or its equivalent.

3667 “Primary care provider”, a health care professional qualified to provide general medical care for
3668 common health care problems who (1) supervises, coordinates, prescribes, or otherwise provides
3669 or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains
3670 continuity of care within the scope of practice.

3671 Section 2. The commissioner and the group insurance commission shall require that all carriers
3672 recognize physician assistants as participating providers subject to section 3 and shall include

3673 coverage on a nondiscriminatory basis to their insureds for care provided by physician assistants
3674 for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include
3675 benefits for primary care, intermediate care and inpatient care, including care provided in a
3676 hospital, clinic, professional office, home care setting, long-term care setting, mental health or
3677 substance abuse program, or any other setting when rendered by a physician assistant who is a
3678 participating provider and is practicing within the scope of his or her professional authority as
3679 defined by statute, rule and physician delegation to the extent that such policy or contract
3680 currently provides benefits for identical services rendered by a provider of health care licensed
3681 by the commonwealth.

3682 Section 3. A participating provider physician assistant practicing within the scope of such
3683 physician assistant's license, including all regulations requiring collaboration with or supervision
3684 by a physician under section 9E of chapter 112, shall be considered qualified within the carrier's
3685 definition of primary care provider to an insured.

3686 Section 4. Notwithstanding any general or special law to the contrary, a carrier that requires the
3687 designation of a primary care provider shall provide its insured with an opportunity to select a
3688 participating provider physician assistant as a primary care provider.

3689 Section 5. Notwithstanding any general or special law to the contrary, a carrier shall ensure that
3690 all participating provider physician assistants are included on any publicly accessible list of
3691 participating providers for the carrier.

3692 Section 6. A complaint for noncompliance against a carrier shall be filed with and investigated
3693 by the commissioner or the group insurance commission, whichever shall have regulatory

3694 authority over the carrier. The commissioner and the group insurance commission shall
3695 promulgate regulations to enforce this chapter.

3696 SECTION 176. Section 8A of chapter 180 of the General Laws, as appearing in the 2010
3697 Official Edition, is hereby amended by striking out, in line 101, the words “finance and policy”
3698 and inserting in place thereof the following words:—cost and quality.

3699 SECTION 177. Section 9 of chapter 209C of the General Laws is hereby amended by striking
3700 out, in line 37, as so appearing, the words “finance and policy” and inserting in place thereof the
3701 following words:— cost and quality.

3702 SECTION 178. Section 60K of chapter 231 of the General Laws, as so appearing, is hereby
3703 amended by striking out, in line 14, the figure “4” and inserting in place thereof the following
3704 figurer:— 2.

3705 SECTION 180. Section 85K of said chapter 231, as so appearing, is hereby amended by inserting
3706 after the word “costs”, in line 8, with the following words:—

3707 ; provided, however, in the context of medical malpractice claims against a non-profit charity
3708 providing health care, such cause of action shall not exceed the sum of $100,000, exclusive of
3709 interest and costs.

3710 SECTION 179. Chapter 231 of the General Laws is hereby amended by inserting after section
3711 60K the following 3 sections:—

3712 Section 60L. (a) Except as provided in this section a person shall not commence an action
3713 against a provider of health care as defined in the seventh paragraph of section 60B unless the

3714 person has given the health care provider written notice under this section of not less than 182
3715 days before the action is commenced.

3716 (b) The notice of intent to file a claim required under subsection (a) shall be mailed to the last
3717 known professional business address or residential address of the health care provider who is the
3718 subject of the claim.

3719 (c) The 182 day notice period in subsection (a) shall be shortened to 91 days if either of the
3720 following conditions exists:

3721 (1) the claimant has previously filed the 182 day notice required against another health care
3722 provider involved in the claim; and

3723 (2) the claimant has filed a complaint and commenced an action alleging medical malpractice
3724 against 1 or more of the health care providers involved in the claim.

3725 (d) The 182 day notice of intent described in subsection (a) shall not be required if the claimant
3726 did not identify and could not reasonably have identified a health care provider to which notice
3727 must be sent as a potential party to the action before filing the complaint.

3728 (e) The notice given to a health care provider under this section shall contain a statement of at
3729 least all of the following:

3730 (1) the factual basis for the claim;

3731 (2) the applicable standard of care alleged by the claimant;

3732 (3) the manner in which it is claimed that the applicable standard of care was breached by the
3733 health care provider;

3734 (4) the alleged action that should have been taken to achieve compliance with the alleged
3735 standard of care;

3736 (5) the manner in which it is alleged the breach of the standard of care was a proximate cause of
3737 the injury claimed in the notice; and

3738 (6) the names of all health care providers the claimant is notifying under this section in relation
3739 to the claim.

3740 (f) Fifty-six days after giving notice under this section, the claimant shall allow the health care
3741 provider receiving the notice access to all of the medical records related to the claim that are in
3742 the claimant's control, and shall furnish release for any medical records related to the claim that
3743 are not in the claimant's control, but of which the claimant has knowledge. This subsection does
3744 not restrict a patient's right of access to his or her medical records under any other provision of
3745 law.

3746 (g) Within 150 days after receipt of notice under this section, the health care provider or
3747 authorized representative against whom the claim is made shall furnish to the claimant or his or
3748 her authorized representative a written response that contains a statement including the
3749 following:

3750 (1) the factual basis for the defense, if any, to the claim;

3751 (2) the standard of care that the health care provider claims to be applicable to the action;

3752 (3) the manner in which it is claimed by the health care provider that there was or was not
3753 compliance with the applicable standard of care; and

3754 (4) the manner in which the health care provider contends that the alleged negligence of the
3755 health care provider was or was not a proximate cause of the claimant's alleged injury or alleged
3756 damage.

3757 (h) If the claimant does not receive the written response required under subsection (g) within the
3758 required 150 day time period, the claimant may commence an action alleging medical
3759 malpractice upon the expiration of the 150 day period. Further, if a provider fails to respond
3760 within 150 days and that fact is made known to the court in the plaintiffs' complaint or by any
3761 other means then interest on any judgment against that provider will accrue and be calculated
3762 from the date that the notice was filed rather than the date that suit is filed. At any time before
3763 the expiration of the 150 day period, the claimant and the provider may agree to an extension of
3764 the 150 day period.

3765 (i) If at any time during the applicable notice period under this section a health care provider
3766 receiving notice under this section informs the claimant in writing that the health care provider
3767 does not intend to settle the claim within the applicable notice period, the claimant may
3768 commence an action alleging medical malpractice against the health care provider, so long as the
3769 claim is not barred by the statute of limitations or repose.

3770 (j) As to any lawsuit against any health care provider filed within 6 months of the statute of
3771 limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any
3772 claimant, compliance with this section is not required.

3773 (k) Nothing in this act shall prohibit the filing of suit at any time in order to seek court orders to
3774 preserve and permit inspection of tangible evidence.

3775 SECTION 181. Chapter 233 of the General Lawsis hereby amended by inserting after section
3776 79K the following section:-

3777 Section 79L. (a) As used in this section the following terms shall have the following meaning:

3778 "Health care provider", any of the following heath care professionals licensed pursuant to
3779 chapter 112: a physician, physician assistant, podiatrist, physical therapist, occupational
3780 therapist, dentist, dental hygienist optometrist, nurse, nurse practitioner, chiropractor,
3781 psychologist, independent clinical social worker, speech-language pathologist, audiologist,
3782 marriage and family therapist and a mental health counselor. The term shall also include any
3783 corporation, professional corporation, partnership, limited liability company, limited liability
3784 partnership, authority, or other entity comprised of such health care providers.

3785 "Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health
3786 agency. The term shall also include any corporation, professional corporation, partnership,
3787 limited liability company, limited liability partnership, authority, or other entity comprised of
3788 such facilities.

3789 "Unanticipated outcome", the outcome of a medical treatment or procedure, whether or not
3790 resulting from an intentional act, that differs from an intended result of such medical treatment or
3791 procedure.

3792 (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly
3793 experiencing an unanticipated outcome of medical care, any and all statements, affirmations,
3794 gestures, activities or conduct expressing benevolence, regret, apology, sympathy,
3795 commiseration, condolence, compassion, mistake, error, or a general sense of concern which are
3796 made by a health care provider, facility or an employee or agent of a health care provider or

3797 facility, to the patient, a relative of the patient, or a representative of the patient and which relate
3798 to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative
3799 proceeding, unless the maker of the statement or a defense expert witness, when questioned
3800 under oath during the litigation about facts and opinions regarding any mistakes or errors that
3801 occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in
3802 which case the statements and opinions made about the mistake or error are admissible for all
3803 purposes. In situations where a patient suffers an unanticipated outcome with significant medical
3804 complication resulting from the provider's mistake, the health care provider, facility, or an
3805 employee or agent of a health care provider or facility shall fully inform the patient, and when
3806 appropriate the patient's family, about said unanticipated outcome.

3807 SECTION 182. Section 3 of chapter 258C of the General Laws, as appearing in the 2010
3808 Official Edition, is hereby amended by striking out, in line 36, the words "finance and policy"
3809 and inserting in place thereof the following words:—cost and quality.

3810 SECTION 183. Section 7 of chapter 268A of the General Laws, as so appearing, is hereby
3811 amended by striking out, in line 50, the words "policy and finance" and inserting in place thereof
3812 the following words:—cost and quality.

3813 SECTION 151A Chapter 176O of the General Laws is hereby amended by striking out the title
3814 and inserting in place thereof the following title:- Health Care Consumer Protections.

3815 SECTION 186A. Sections 15 and 15 of chapter 305 of the acts of 2008 are hereby repealed.

3816 SECTION 184. Section 54 of chapter 288 of the acts of 2010 is hereby repealed.

3817 SECTION 185. Nothing in this act shall be construed to preclude an individual from obtaining
3818 additional insurance or paying out of pocket for any medical service not covered by the
3819 individual's health plan.

3820 SECTION 186. Following an evaluation by the office of the attorney general, pursuant to
3821 section 11M of Chapter 12 of the General Laws, relating to the need of the commonwealth to
3822 obtain waivers from certain provisions of federal law including, from the federal office of the
3823 inspector general, a waiver of the provisions or expansion of the "safe harbors" provided for
3824 under 42 U.S.C. section 1320a-7b; and a waiver of the provisions of 42 U.S.C. section 1395nn(a)
3825 to (e), and upon a determination by the attorney general that such waiver or exemption is
3826 necessary, the division of health care cost and quality shall, by August 15, 2012, request from the
3827 federal office of the inspector general the following:(i) a waiver of the provisions of, or
3828 expansion of the "safe harbors" to, 42 U.S.C. section 1320a-7b and implementing regulations or
3829 any other necessary authorization the division determines may be necessary to permit certain
3830 shared risk and other risk sharing arrangements among providers and ACOs; and

3831 (ii) a waiver of or exemption from the provisions of 42 U.S.C. section 1395nn(a) to (e),
3832 inclusive, and implementing regulations or other necessary authorization the division determines
3833 may be necessary to permit physician referrals to other providers as needed to support the
3834 transition to and implementation of alternative payment systems and formation of ACOs.

3835 SECTION 187. Notwithstanding any general or special law, rule or regulation to the contrary,
3836 the commissioner of insurance shall promulgate regulations requiring any carrier, as defined in
3837 chapter 176O of the general laws, and their contractors to effectively comply with and
3838 implement the federal Mental Health Parity and Addiction Equity Act of 2008, Section 511 of

3839 Public Law 110-343. The commissioner of insurance shall promulgate said regulations not later
3840 than 90 days after the effective date of this act. Said regulations shall be implemented as part of
3841 any provider contracts and any carrier's health benefit plans which are delivered, issued, entered
3842 into, renewed, or amended on or after this act's effective date.

3843 Starting on July 1, 2013, the commissioner of insurance shall require all carriers, as so defined,
3844 and their contractors, to submit an annual report to the division of insurance, which shall be a
3845 public record, certifying and outlining how their health benefit plans are in compliance with the
3846 federal Mental Health Parity Act and the provisions of this section. The division of insurance
3847 shall forward all such reports to the office of the attorney general for verification of compliance
3848 with the federal Mental Health Parity Act.

3849 SECTION 188. Notwithstanding any general or special law, rule or regulation to the contrary,
3850 the office of Medicaid shall promulgate regulations requiring any Medicaid health plan and
3851 managed care organization and their health plans and any behavioral health management firm
3852 and third party administrator under contract with a Medicaid managed care organization to
3853 effectively comply with and implement the federal Mental Health Parity and Addiction Equity
3854 Act of 2008, Section 511 of Public Law 110-343. The office of Medicaid shall promulgate said
3855 regulations not later than 90 days after the effective date of this act. Said regulations shall be
3856 implemented as part of any provider contracts and any carrier's health benefit plans which are
3857 delivered, issued, entered into, renewed, or amended on or after this act's effective date.

3858 Starting on July 1, 2013, the office of Medicaid shall submit an annual report to the co-chairs of
3859 the joint committee on health care financing, the co-chairs of the joint committee on mental
3860 health and substance abuse, the clerk of the senate, and the clerk of the house of representatives

3861 certifying and outlining how the health benefit plans under the office of Medicaid, and any
3862 contractors, are in compliance with the federal Mental Health Parity Act and the provisions of
3863 this section. The office of Medicaid shall forward all such reports to the office of the attorney
3864 general for verification of compliance with the federal Mental Health Parity Act.

3865 SECTION 189. Notwithstanding any general or special law or rule or regulation to the contrary,
3866 the group insurance commission, office of Medicaid, and the commonwealth connector authority
3867 may offer smart tiered plans, as defined in section 11 of chapter 176J, on January 1, 2014.

3868 SECTION 190. (a) Notwithstanding any general or special law to the contrary, this section shall
3869 facilitate the orderly transfer of the employees, proceedings, rules and regulations, property and
3870 legal obligations of the following functions of state government from the transferor agency to the
3871 transferee agency, defined as follows: the functions of the Massachusetts eHealth Institute,
3872 established under section 6D of chapter 40J of the General Laws, as the transferor agency, to the
3873 division of health care cost and quality established under section 2 of chapter 118G of the
3874 General Laws, as the transferee agency.

3875 (b) The employees of the transferor agency, including those who were appointed immediately
3876 before the effective date of this act and who hold permanent appointment in positions classified
3877 under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A
3878 of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are
3879 hereby transferred to the transferee agency, without interruption of service within the meaning of
3880 said section 9A of said chapter 31, without impairment of seniority, retirement or other rights of
3881 the employee, and without reduction in compensation or salary grade, notwithstanding any
3882 change in title or duties resulting from such reorganization, and without loss of accrued rights to

3883 holidays, sick leave, vacation and benefits, and without change in union representation or
3884 certified collective bargaining unit as certified by the state department of labor relations or in
3885 local union representation or affiliation. Any collective bargaining agreement in effect
3886 immediately before the transfer date shall continue in effect and the terms and conditions of
3887 employment therein shall continue as if the employees had not been so transferred. The
3888 reorganization shall not impair the civil service status of any such reassigned employee who
3889 immediately before the effective date of this act either holds a permanent appointment in a
3890 position classified under chapter 31 of the General Laws or has tenure in a position by reason of
3891 section 9A of chapter 30 of the General Laws. Notwithstanding any other general or special law
3892 to the contrary, all such employees shall continue to retain their right to collectively bargain
3893 pursuant to chapter 150E of the General Laws and shall be considered employees for the
3894 purposes of said chapter 150E. Nothing in this section shall be construed to confer upon any
3895 employee any right not held immediately before the date of said transfer, or to prohibit any
3896 reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or abolition of
3897 position not prohibited before such date.

3898 (c) All petitions, requests, investigations and other proceedings appropriately and duly brought
3899 before the transferor agency or duly begun by the transferor agency and pending before the
3900 effective date of this act, shall continue unabated and remain in force, but shall be assumed and
3901 completed by the transferee agency.

3902 (d) All orders, rules and regulations duly made and all approvals duly granted by the transferor
3903 agency, which are in force immediately before the effective date of this act, shall continue in
3904 force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in
3905 accordance with law, by the transferee agency.

3906 (e) All books, papers, records, documents, equipment, buildings, facilities, funds, accounts, cash
3907 and other property, both personal and real, including all such property held in trust, which
3908 immediately before the effective date of this act are in the custody of the transferor agency shall
3909 be transferred to the transferee agency.

3910 (f) All duly existing contracts, leases and obligations of the transferor agency shall continue in
3911 effect but shall be assumed by the transferee agency.

3912 (g) The comptroller shall be authorized to take any actions necessary to support the transfers
3913 outlined in this section. No existing right or remedy of any character shall be lost, impaired or
3914 affected by this act.

3915 SECTION 191. (a) Notwithstanding any general or special law to the contrary, this section shall
3916 facilitate the orderly transfer of the employees, proceedings, rules and regulations, property and
3917 legal obligations of the following functions of state government from the transferor agency to the
3918 transferee agency, defined as follows: the functions of the Massachusetts Health Information
3919 Technology Council, established under section 6D of chapter 40J of the General Laws, as the
3920 transferor agency, to the executive office of health and human services, as the transferee agency.

3921 (b) The employees of the transferor agency, including those who were appointed immediately
3922 before the effective date of this act and who hold permanent appointment in positions classified
3923 under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A
3924 of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are
3925 hereby transferred to the transferee agency, without interruption of service within the meaning of
3926 said section 9A of said chapter 31, without impairment of seniority, retirement or other rights of
3927 the employee, and without reduction in compensation or salary grade, notwithstanding any

3928 change in title or duties resulting from such reorganization, and without loss of accrued rights to
3929 holidays, sick leave, vacation and benefits, and without change in union representation or
3930 certified collective bargaining unit as certified by the state department of labor relations or in
3931 local union representation or affiliation. Any collective bargaining agreement in effect
3932 immediately before the transfer date shall continue in effect and the terms and conditions of
3933 employment therein shall continue as if the employees had not been so transferred. The
3934 reorganization shall not impair the civil service status of any such reassigned employee who
3935 immediately before the effective date of this act either holds a permanent appointment in a
3936 position classified under chapter 31 of the General Laws or has tenure in a position by reason of
3937 section 9A of chapter 30 of the General Laws. Notwithstanding any other general or special law
3938 to the contrary, all such employees shall continue to retain their right to collectively bargain
3939 pursuant to chapter 150E of the General Laws and shall be considered employees for the
3940 purposes of said chapter 150E. Nothing in this section shall be construed to confer upon any
3941 employee any right not held immediately before the date of said transfer, or to prohibit any
3942 reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or abolition of
3943 position not prohibited before such date.

3944 (c) All petitions, requests, investigations and other proceedings appropriately and duly brought
3945 before the transferor agency or duly begun by the transferor agency and pending before it before
3946 the effective date of this act, shall continue unabated and remain in force, but shall be assumed
3947 and completed by the transferee agency.

3948 (d) All orders, rules and regulations duly made and all approvals duly granted by the transferor
3949 agency, which are in force immediately before the effective date of this act, shall continue in

3950 force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in
3951 accordance with law, by the transferee agency.

3952 (e) All books, papers, records, documents, equipment, buildings, facilities, funds, accounts, cash
3953 and other property, both personal and real, including all such property held in trust, which
3954 immediately before the effective date of this act are in the custody of the transferor agency shall
3955 be transferred to the transferee agency.

3956 (f) All duly existing contracts, leases and obligations of the transferor agency shall continue in
3957 effect but shall be assumed by the transferee agency.

3958 (g) The comptroller shall be authorized to take any actions necessary to support the transfers
3959 outlined in this section. No existing right or remedy of any character shall be lost, impaired or
3960 affected by this act.

3961 SECTION 192. (a) Notwithstanding any general or special law to the contrary, this section shall
3962 facilitate the orderly transfer of the employees, proceedings, rules and regulations, property and
3963 legal obligations of the following functions of state government from the transferor agency to the
3964 transferee agency, defined as follows: the functions of the division of health care finance and
3965 policy, as the transferor agency, to the division of health care cost and quality, as the transferee
3966 agency.

3967 (b) The employees of the transferor agency, including those who were appointed immediately
3968 before the effective date of this act and who hold permanent appointment in positions classified
3969 under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A
3970 of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are
3971 hereby transferred to the transferee agency, without interruption of service within the meaning of

said section 9A of said chapter 31, 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 department 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 chapter 31 of the General Laws or has tenure in a position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding any other general or special law to the contrary, all such employees shall continue to retain their right to collectively bargain pursuant to 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.

3994 (d) All orders, rules and regulations duly made and all approvals duly granted by the transferor
3995 agency, which are in force immediately before the effective date of this act, shall continue in
3996 force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in
3997 accordance with law, by the transferee agency.

3998 (e) All books, papers, records, documents, equipment, buildings, facilities, funds, accounts, cash
3999 and other property, both personal and real, including all such property held in trust, which
4000 immediately before the effective date of this act are in the custody of the transferor agency shall
4001 be transferred to the transferee agency.

4002 (f) All duly existing contracts, leases and obligations of the transferor agency shall continue in
4003 effect but shall be assumed by the transferee agency.

4004 (g) The comptroller shall be authorized to take any actions necessary to support the transfers
4005 outlined in this section. No existing right or remedy of any character shall be lost, impaired or
4006 affected by this act.

4007 SECTION 193 Notwithstanding any general or special law to the contrary, the secretary of
4008 health and human services shall transfer any remaining funds from the distressed provider
4009 expendable trust fund, established in chapter 241 of the acts of 2004, to the distressed hospital
4010 trust fund, established in section 2GGGG of chapter 29 of the General Laws.

4011 SECTION 194. Notwithstanding any general or special law to the contrary, the division of
4012 health care cost and quality, established under chapter 118G of the General Laws, shall continue
4013 to collect all assessments formerly collected by the division of health care finance and policy,
4014 including, without limitation, health safety net assessments, nursing home user fees and child
4015 immunization assessments.

4016 SECTION 195. Notwithstanding any general or special law or rule or regulation to the contrary,
4017 the division of insurance shall conduct a study on the adequacy of reserves for both payers and
4018 providers. The study shall include the following: (1) current reserves held by payers, (2) current
4019 reserves held by providers, (3) a formula to calculate the minimum necessary reserves for payors
4020 based on their levels of risk, (4) a formula to calculate the minimum necessary reserves for
4021 providers based on their levels of risk, and (5) a threshold of excess reserves. Minimum
4022 necessary reserves shall mean the amount of reserves required for a payer or provider to be
4023 fiscally solvent. The threshold of excess reserves shall represent an amount beyond what a payer
4024 or provider should reasonably hold above the necessary reserves amount. The level of risk shall
4025 mean the possible percentages of risk a provider or payer has in any risk sharing arrangement.
4026 Upon completion of this study, the division shall promulgate all necessary regulations to
4027 implement the findings of the study.

4028 The division shall then issue a report on its findings to the senate and house committees on ways
4029 and means and the joint committee on health care financing by July 1, 2013.

4030 SECTION 196. Notwithstanding any general or special law or rule or regulation to the contrary,
4031 the health care workforce center shall investigate the possibility of dedicating funds for joint
4032 appointments for clinicians with clinical agencies and universities. As part of the arrangement,
4033 clinicians pursuing doctoral education would receive tuition and fee reimbursement for
4034 maintaining a clinical position and teaching at the entry level of the academic program while
4035 pursuing their doctoral degree.
4036 SECTION 197. The department of public health, on or before February 1, 2013, shall promulgate
4037 regulations or guidelines to implement the findings of hearings conducted under section 226 of

4038 chapter 111 of the General Laws as to what constitutes an “emergency situation”, warranting
4039 mandatory overtime of nurses.

4040 SECTION 198. The department of public health, on or before January 1, 2014, shall promulgate
4041 regulations to establish a system to levy an administrative fine on any facility that violates this
4042 section or any regulation issued under this section. The fine shall be not less than $100 and not
4043 greater than $1,000 for each violation and fines collected shall be dedicated to the department of
4044 public health’s statewide sexual assault nurse examiner program. Said regulations shall also
4045 establish an independent appeals process for penalized entities.

4046 SECTION 199. MassHealth shall implement, no later than July 1, 2013, the Express Lane re-
4047 enrollment program for streamlined eligibility procedures to renew eligibility for parents with
4048 children who are enrolled in the SNAP program.

4049 SECTION 200. Acute hospitals and ambulatory surgical centers shall be assessed a one-time
4050 surcharge to be paid to the division of health care cost and quality, hereinafter referred to as the
4051 division, for the distressed hospital trust fund, created under section 2GGGG of chapter 29 of the
4052 General Laws, to be paid by July 1, 2013. The surcharge amount shall equal the product of (i) the
4053 surcharge percentage and (ii) the assessment. The division shall calculate the surcharge
4054 percentage by dividing the acute hospital or ambulatory surgical center’s patient service revenue
4055 by the total patient service revenues of acute hospitals and ambulatory surgical centers paying an
4056 assessment under this section. The assessment shall equal the product of (i) the statewide
4057 medical spend in calendar year 2011 and (ii) 0.1 per cent. The division shall determine the
4058 surcharge percentage for the one-time assessment by December 31, 2012. In the determination of
4059 the surcharge percentage, the division shall use the best data available as determined by the
4060 division and may consider the effect on projected surcharge payments of any modified or waived

4061 enforcement pursuant to subsection (g). The division shall incorporate all adjustments, including,
4062 but not limited to, updates or corrections or final settlement amounts, by prospective adjustment
4063 rather than by retrospective payments or assessments. The division may waive the assessment for
4064 an acute hospital or ambulatory surgical center, if it finds the hospital or ambulatory surgical
4065 center is unable to pay the assessment; provided that if an acute hospital or ambulatory surgical
4066 is a part of a system, then the system as a whole shall be financially reviewed. The division shall
4067 make a determination for waiver based on the following factors: (A) cash and investments on
4068 hand, (B) total revenues, (C) total case and investments, (D) total reserves,(E) total profits,
4069 margins or surplus, (F) earnings before interest, depreciation and amortization, (G)
4070 administrative expense ratio, and (H) the compensation of executive managers and board
4071 members; provided however, any hospital system with less than $1,000,000,000 in total net
4072 assets or more than 50 per cent of revenues from public payers shall be exempt from this section.

4073 (b) Surcharge payors shall be assessed a one-time surcharge to be paid to the division for the
4074 distressed hospital trust fund, created under section 2GGGG of chapter 29 of the General Laws
4075 by July 1, 2013. The surcharge amount shall equal the product of (i) the surcharge percentage
4076 and (ii) the assessment. The division shall calculate the surcharge percentage by dividing the
4077 surcharge payor's payments for acute hospital services by the payment for acute hospital services
4078 by all surcharge payors. The assessment shall equal the product of (i) the statewide medical
4079 spend in calendar year 2011 and (ii) 0.2 per cent. The division shall determine the surcharge
4080 percentage for the one-time assessment by December 31, 2012; provided further that such one-
4081 time assessment funds shall be collected in such manner to allow periodic payments over a three
4082 year time period. In the determination of the surcharge percentage, the division shall use the best
4083 data available as determined by the division and may consider the effect on projected surcharge

4084 payments of any modified or waived enforcement pursuant to subsection (g). The division shall
4085 incorporate all adjustments, including, but not limited to, updates or corrections or final
4086 settlement amounts, by prospective adjustment rather than by retrospective payments or
4087 assessments. The division may waive the assessment for a payor, if it finds the payor is unable to
4088 pay. The division shall take into account the following factors when determining if a payor is
4089 able to pay: (A) total revenues, (B) total premium receipts, (C) total reserves, (D) total profits,
4090 margins or surplus, (E) medical loss ratio and administrative expense ratio, and (F) the
4091 compensation of the executive managers and board members.

4092 (c) The division shall specify by regulation appropriate mechanisms that provide for
4093 determination and payment of an acute hospital, an ambulatory surgical center, or a surcharge
4094 payor's liability, including requirements for data to be submitted by acute hospitals, ambulatory
4095 surgical centers, and surcharge payors.
4096 (d) A hospital's liability to the fund shall in the case of a transfer of ownership be assumed by
4097 the successor in interest to the hospital.
4098 (e) An ambulatory surgical center's liability to the fund shall in the case of a transfer of
4099 ownership be assumed by the successor in interest to the ambulatory surgical center.
4100 (f) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
4101 assumed by the successor in interest to the surcharge payor.
4102 (g) The division shall establish by regulation an appropriate mechanism for enforcing an acute
4103 hospital, ambulatory surgical center or surcharge payor's liability to the fund if an acute hospital,
4104 ambulatory surgical center or surcharge payor does not make a scheduled payment to the fund;
4105 provided, however, that the division may, for the purpose of administrative simplicity, establish
4106 threshold liability amounts below which enforcement may be modified or waived. Such

4107 enforcement mechanism may include assessment of interest on the unpaid liability at a rate not to
4108 exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5
4109 per cent per month. Such enforcement mechanism may also include notification to the office of
4110 Medicaid requiring an offset of payments on the claims of the acute hospital or surcharge payor,
4111 any entity under common ownership or any successor in interest to the acute hospital or
4112 surcharge payor, from the office of Medicaid in the amount of payment owed to the fund
4113 including any interest and penalties, and to transfer the withheld funds into said fund. If the
4114 office of Medicaid offsets claims payments as ordered by the division, the office of Medicaid
4115 shall be considered not to be in breach of contract or any other obligation for payment of non-
4116 contracted services, and an acute hospital, ambulatory surgical center or surcharge payor whose
4117 payment is offset under an order of the division shall serve all Title XIX recipients under the
4118 contract then in effect with the executive office of health and human services. In no event shall
4119 the division direct the office of Medicaid to offset claims unless the acute hospital or surcharge
4120 payor has maintained an outstanding liability to the fund for a period longer than 45 days and has
4121 received proper notice that the division intends to initiate enforcement actions under regulations
4122 promulgated by the division.
4123 (h) If an acute hospital or surcharge payor fails to file any data, statistics or schedules or other
4124 information required under this chapter or by any regulation promulgated by the division, the
4125 division shall provide written notice to the acute hospital, ambulatory surgical center or
4126 surcharge payor. If an acute hospital, ambulatory surgical center or surcharge payor fails to
4127 provide required information within 14 days after the receipt of written notice, or falsifies the
4128 same, he shall be subject to a civil penalty of not more than $5,000 for each day on which the
4129 violation occurs or continues, which penalty may be assessed in an action brought on behalf of

4130 the commonwealth in any court of competent jurisdiction. The attorney general shall bring any
4131 appropriate action, including injunctive relief, necessary for the enforcement of this chapter.
4132 (i) Acute hospitals shall not seek an increase in rates to pay for this assessment.
4133 (j) Ambulatory surgical centers shall not seek an increase in rates to pay for this assessment
4134 (k) Surcharge payors shall not seek an increase in premiums to pay for this assessment.

4135 SECTION 201. An accountable care organization, as defined in chapter 118I of the General
4136 Laws, shall have an interoperable electronic medical record system available for ACO
4137 participants to coordinate care, share information and electronic prescribing capabilities by
4138 January 1, 2017.

4139 SECTION 202. There shall be a task force consisting of 18 members with expertise in behavioral
4140 health treatment, service delivery, the integration of behavioral health with primary care, and
4141 such reimbursement systems. Members shall include one representative from each of the
4142 following organizations representing mental health professionals and clinical, hospital and
4143 consumer advocacy groups: Massachusetts Psychiatric Society, Massachusetts Psychological
4144 Association, National Association of Social Workers- Massachusetts Chapter, Massachusetts
4145 Mental Health Counselors Association, Nurses United for Responsible Services, Massachusetts
4146 Association for Registered Nurses, Massachusetts Association of Behavioral Health Systems,
4147 Association for Behavioral Healthcare, Mental Health Legal Advisors Committee, National
4148 Alliance for the Mentally Ill, Children's Mental Health Campaign, Home Care Alliance of
4149 Massachusetts, National Empowerment Center, Massachusetts Organization for Addiction
4150 Recovery, Recovery Homes Collaborative, and 3 members chosen by the Governor . The task
4151 force shall report to the division its findings and recommendations relative to (a) the most
4152 effective and appropriate approach to including behavioral health services in the array of services

4153 provided by ACOs and patient-centered medical homes, including transition planning for
4154 providers and maintaining continuity of care; (b) how current prevailing reimbursement methods
4155 and covered behavioral health benefits may need to be modified to achieve more cost effective,
4156 integrated and high quality behavioral health outcomes including attention to interoperable
4157 electronic health records; (c) the extent to which and how payment for behavioral health services
4158 should be included under alternative payment methodologies established or regulated under this
4159 act including how mental health parity and patient choice of providers and services could be
4160 achieved and the design and use of medical necessity criteria and protocols; (d) how best to
4161 educate all providers to recognize behavioral health conditions and make appropriate decisions
4162 regarding referral to behavioral health services; (e) how best to educate all providers about the
4163 effects of cardiovascular disease, diabetes, and obesity on patients with serious mental illness;
4164 and (f) the unique privacy factors required for the integration of behavioral health information
4165 into interoperatable electronic health records. The first meeting shall be convened within 60 days
4166 after passage of this act. The task force shall submit its findings, recommendations, and any
4167 proposed legislation and regulatory changes to the joint committee on mental health and
4168 substance abuse, the joint committee on health care financing and the division no later than
4169 February 1, 2013.

4170 SECTION 203. Section 27 of chapter 32A of the General Laws, as inserted by section 20 of this
4171 act, shall take effect on January 1, 2014.

4172 SECTION 204. Section 30 of chapter 32B of the General Laws, as inserted by section 21 of this
4173 act, shall take effect on January 1, 2014.

4174 SECTION 205. Section 65 of chapter 111 of the General Laws, as inserted by section 83 of this
4175 act, shall take effect on July 1, 2013.

4176 SECTION 206. Section 225 of chapter 111 of the General Laws, as inserted by section 83 of this
4177 act, shall take effect on July 1, 2013.
4178 SECTION 207. Subsection (e) of section 226 of chapter 111 of the General Laws, as inserted by
4179 section 83 of this act, shall take effect on April 15, 2013.
4180 SECTION 208. Subsection (a) of section 43 of chapter 118G of the General Laws, as inserted
4181 by SECTION 121 of this act, shall take effect on January 1, 2014.
4182 SECTION 209. Subsection (c) of section 43 of chapter 118G of the General Laws, as inserted
4183 by SECTION 121 of this act, shall take effect on January 1, 2015.
4184 SECTION 210. Section 8 of chapter 118I of the General Laws, as inserted by section 123 of this
4185 act, shall take effect on January 1, 2017.
4186 SECTION 211. Section 9 of chapter 118J of the General Laws, as inserted by section 123 of this
4187 act, shall take effect on January 1, 2017.
4188 SECTION 212. Sections 228 and 229 of chapter 175 of the General Laws, as inserted by
4189 SECTION 136 of this act, shall take effect on July 1, 2013.
4190 SECTION 213. Section 35 of chapter 176A of the General Laws, as inserted by section 139 of
4191 this act, shall take effect on January 1, 2014.
4192 SECTION 214. Section 23 of chapter 176B of the General Laws, as inserted by section 140 of
4193 this act, shall take effect on January 1, 2014.
4194 SECTION 215. Section 31 of chapter 176G of the General Laws, as inserted by section 141 of
4195 this act, shall take effect on January 1, 2014.
4196 SECTION 216. Section 16 of chapter 176J of the General Laws, as inserted by section 150 of
4197 this act, shall take effect on January 1, 2014.
4198 SECTION 217 . Section 120 of this act shall take effect on July 1, 2013.

SECTION 218. Sections 145 and 146 shall take effect on January 1, 2016.

SECTION 219. Section 9 of Chapter 330 of the Statutes of 1994, as amended by Section 3 of Chapter 63 of the Statutes of 1995, is amended by striking out section 6 therein and inserting in place thereof the following:-

Section 6. Upon the approval of the commissioner, the medical professional mutual insurance company, may for any purposes, including, but not limited to the fixing of separate percentages of dividends under section eighty of chapter one hundred and seventy-five, consider the business of each category of health care provider as a separate line of business; provided, however, that the doctor of dental science category of insured shall continue to be treated as a separate line of business by the medical professional mutual insurance company to the extent required by chapter ninety-two of the acts of nineteen hundred and ninety-one, and, as promptly as possible after the effective date of this act, any excess surplus of the association as determined by the commissioner attributable to the doctor of dental science category of business as of the effective date of the conversion shall be paid as a dividend by the mutual company for the benefit of the association's doctor of dental science policyholders entitled thereto in accordance with the methodology established and employed by the association for the payment of dividends to its doctor of dental science policyholders prior to the date of the conversion. Any person in the doctor of dental science category of insureds who was insured by the association at the time of the conversion may elect to continue to be insured by the mutual company by specifically assigning in writing this first dividend to be paid after the effective date of this act back to the mutual company.

4220 Effective January first, two thousand and eleven, all excess surplus as determined by the
4221 commissioner, allocable to doctor of dental science policies issued by the company at any time
4222 on or prior to December thirty-first, two thousand and ten, shall be paid annually, on or about
4223 July first of the following year, as a dividend to those persons, firms and entities entitled thereto,
4224 pursuant to the methodology established and employed by the association for the distribution of
4225 such dividends prior to the conversion. No portion of such excess surplus as determined by the
4226 commissioner shall be used or allocated for any other purpose or purposes and upon the payment
4227 of such dividend, there shall be no excess surplus allocable to those doctor of dental science
4228 policies issued by the company at any time on or prior to December thirty-first, two thousand
4229 and ten. The medical professional mutual insurance company shall annually notify each person,
4230 firm or entity entitled to such dividend of the amount of such dividend to which he is entitled.
4231 For the purposes of this section, "excess surplus" shall mean any surplus allocable to the
4232 association's doctor of dental science category of insureds beyond an amount determined by the
4233 commissioner to be reasonably necessary as a margin against adverse development.

4234 SECTION 220. Section 3 of chapter 176D, as appearing in the 2010 official edition, is hereby
4235 amended by inserting after every occurrence of words “medical service corporation”, the
4236 following words:- “accountable care organization”.

4237 SECTION 221. Section 66 shall take effect on January 1, 2014.

4238 SECTION 222. Notwithstanding any general or special law to the contrary, the state Medicaid
4239 office is hereby authorized to establish a pilot program with an external service provider to
4240 determine the effectiveness of various fraud management tools to identify potential fraud at
4241 claims submission and validation in order to reduce Medicaid fraud prior to payment; provided
4242 further, that said pilot program shall evaluate current Medicaid spending programs and utilize

said fraud management services to determine the efficacy of current practices. The pilot program shall utilize only vendors currently engaged in systemic waste and fraud detection services. Selected vendor(s) shall not use any data provided to them for any other purpose than waste and fraud detection, shall destroy all data after the completion of their evaluation(s) and may not share the results of the data analysis with any outside entities. The executive office of health and human services shall submit 2 reports to the house and senate committees on ways and means detailing recoveries and offsets generated by said audits; provided that the first report shall be delivered no later than February 1, 2014 and that the second report shall be delivered no later than December 31, 2015.

SECTION 223. Chapter 26 of the General Laws is hereby amended by adding after section 8J the following section:-

Section 8K. The commissioner of insurance is hereby authorized to implement applicable provisions of the federal Mental Health Parity and Addiction Equity Act, as codified in Title XVII the Public Health Service Act, 42 USC Sec. 300gg-26, in regards to any carrier licensed under chapters 175, 176A, 176B and 176G.

SECTION 224. Notwithstanding any general or special law to the contrary, physicians licensed in a state other than Massachusetts shall not be prohibited from providing medical advice, diagnoses, treatments and prescriptions when they communicate with patients through internet-based videoconferences when the physicians are located in the state where they are licensed and the patient is located in Massachusetts at the time of the advice, diagnosis, treatment or prescription. Any such internet-based technology shall include visual and audio notice to patients that the physicians are not licensed in Massachusetts.

4265 SECTION 225. The secretary of administration and finance in conjunction with the secretary of
4266 health and human services shall evaluate the feasibility of contracting for recycling durable
4267 medical equipment purchased and issued by the commonwealth through any and all of its
4268 medical assistance programs.

4269 Said evaluation shall include, but not be limited to, a request for qualifications or proposals for
4270 entities capable of developing, implementing and operating a system of recycling whereby an
4271 inventory of such equipment is developed and managed so as to maximize the quality of service
4272 delivery to equipment recipients and to minimize costs and losses attributable to waste, fraud or
4273 abuse.

4274 The secretary of administration and finance shall report to the joint committee on health care
4275 financing, the house committee on ways and means and the senate committee on ways and
4276 means the findings of said evaluation, together with cost estimates for the operation of a
4277 recycling program, estimates of the savings it would generate, and legislative recommendations
4278 not later than October 31, 2012.

4279

4280 SECTION 225A. Chapter 111 of the General Laws is hereby amended by striking out the
4281 definition of "clinic" in section 52, and inserting in place thereof the following definition:-

4282 "Clinic", any entity, however organized, whether conducted for profit or not for profit, which is
4283 advertised, announced, established, or maintained for the purpose of providing ambulatory
4284 medical, surgical, dental, physical rehabilitation, or mental health services. In addition, "clinic"
4285 shall include any entity, however organized, whether conducted for profit or not for profit, which

4286 is advertised, announced, established, or maintained under a name which includes the word
4287 “clinic”, “dispensary”, or “institute”, and which suggests that ambulatory medical, surgical,
4288 dental, physical rehabilitation, or mental health services are rendered therein. With respect to any
4289 entity which is not advertised, announced, established, or maintained under one of the names in
4290 the preceding sentence, “clinic” shall not include a medical office building, a location operated
4291 by a corporation organized under chapter 180 for purposes that include the practice of medicine,
4292 or one or more practitioners engaged in a solo or group practice, however organized, so long as
4293 such practice is wholly owned and controlled by one or more of the practitioners so associated,
4294 or a clinic established solely to provide service to employees or students of such corporation or
4295 institution; provided, however, that an entity exempt from licensure under this sentence may
4296 obtain a license for some, or all, of its locations. For purposes of this section, clinic shall not
4297 include a clinic conducted by a hospital licensed under section fifty-one or by the federal
4298 government or the commonwealth.

4299 SECTION 226. Notwithstanding any general or special law, rule or regulation to the contrary, no
4300 additional benefit, procedure or service shall be required for minimum creditable coverage, so-
4301 called, without prior legislative authorization therefore.

4302 SECTION 227. The office of Medicaid and the department of unemployment assistance shall, in
4303 consultation with the executive office of health and human services, develop and implement a
4304 means by which the office of Medicaid may access information as to the status of or termination
4305 of unemployment benefits and the associated insurance coverage by the medical security plan, as
4306 administered by the executive office of labor and workforce development, for the purposes of
4307 determination of eligibility for those individuals applying for benefits through health care
4308 insurance programs administered by the executive office of health and human services. The

4309 office and the department shall implement this system not later than 3 months following the
4310 passage of this act; provided, however, that if legislative action is required prior to
4311 implementation, recommendations for such action shall be filed with the house and senate clerks
4312 and the joint committee on health care financing not later than 2 months following the passage of
4313 this act.

4314 SECTION 227A. Notwithstanding any law or rule the contrary, for fiscal year 2013, in
4315 establishing Medicaid reimbursement rates for inpatient services provided by chronic disease
4316 rehabilitation hospitals located in the commonwealth that serve solely children and adolescents,
4317 the department of health and human services shall apply a multiplier of 1.5 times the hospital's
4318 inpatient per diem rate in fiscal year 2012. For fiscal year 2014 and beyond, such rates of
4319 reimbursement shall not be lower than the rates in effect for the prior fiscal year.

4320 SECTION 227B. SECTION 227A is hereby repealed.

4321 SECTION 227C. SECTION 227B shall take effect on June 30, 2015.

4322 SECTION 228. Section 47G of chapter 175 of the General Laws, as appearing in the 2008
4323 Official Edition, is hereby amended by adding the following sentence:-- Annual cytologic
4324 screenings performed at the same time as an annual physical exam may not be separately billed
4325 by the health care provider and shall be paid by the insurer.

4326 SECTION 229. Subdivision L of section 110 of said chapter 175, as so appearing, is hereby
4327 amended by adding the following sentence:-- Annual cytologic screenings performed at the
4328 same time as an annual physical exam may not be separately billed by the health care provider
4329 and shall be paid by the insurer.

4330 SECTION 230. Section 8J of chapter 176A, as so appearing, is hereby amended by adding the
4331 following sentence:-- Annual cytologic screenings performed at the same time as an annual
4332 physical exam may not be separately billed by the health care provider and shall be paid by the
4333 insurer.

4334 Section 231. (a) The Director of Medicaid (Director) shall utilize the federal Public Assistance
4335 Reporting Information System (PARIS) to identify veterans
4336 and their dependents or survivors who are enrolled in the MassHealth
4337 program and assist them in obtaining federal veteran health care
4338 benefits.
4339 (b) The Director shall exchange information with PARIS and
4340 identify veterans and their dependents or survivors who are receiving
4341 MassHealth benefits.
4342 (c) The Director shall refer identified veterans who are receiving high-cost services, including
4343 long-term care, to their local veteran service officers (VSOs) to obtain information regarding,
4344 and assistance in obtaining, Department of Veterans' Affairs benefits.
4345 (d) In implementing this section, the Director of Medicaid shall do all of
4346 the following:
4347 (1) Enter into an agreement with the Department of Veterans' Services (DVS) to perform VSO
4348 outreach services. The DVS agreement shall contain performance standards that will allow the
4349 Director to measure the effectiveness of the program established by this section.
4350 (2) Enter into any agreements that are required by the federal
4351 government to utilize the PARIS system.

4352 (3) Perform any information technology activities that are necessary to utilize the PARIS
4353 system.
4354

4355 SECTION 231A. The division of health care cost and quality, established in chapter 118G of the
4356 General Laws, shall investigate and review methods of, and make recommendations relative to,
4357 increasing the use and adoption of health savings accounts and similar tax-favored health plans
4358 and developing and implementing incentives to increase the utilization of health savings
4359 accounts and similar tax favored health plans. The Division shall examine the feasibility of such
4360 accounts and plans for public payers and commercial insurers and the feasibility of a pilot
4361 program. The division shall submit a report of its findings and recommendations to the house and
4362 senate committees on ways and means and the joint committee on health care financing no later
4363 than April 1, 2013.

4364 SECTION 232. Notwithstanding any general or special law to the contrary, the executive office
4365 of health and human services shall conduct a study commission to investigate the
4366 implementation of a pilot program to increase the adoption of health savings accounts and
4367 consumer-driven health plans in the marketplace, including state employees and persons
4368 receiving subsidized health care. The study commission shall be chaired by EOHHS and shall
4369 include: 1 person appointed by the Governor; 1 appointee of the Senate President; 1 appointee of
4370 the Senate Minority Leader; 1 appointee of the Speak of the House; 1 appointee of the House
4371 Minority Leader; 1 representative from the GIC; 1 representative from the banking industry; 1
4372 representative from Mass Health Underwriters Association; 1 representative from the
4373 Association of Health Plans; 1 representative from AIM. The commission shall file a report with
4374 recommendations for implementation with the House Clerk by April 1, 2013.

4375 The scope of the commission shall include, without limitation, identifying: the barriers to full
4376 implementation of health savings accounts, consumer-driver health plans, and high-deductible
4377 health plans; providing greater consumer choice; incentives to increase utilization of health
4378 savings accounts, consumer-driver health plans, and high-deductible health plans.

4379 SECTION 233. Chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is
4380 hereby amended by adding, after section 72Z, the following section:-
4381 Section 72Z½. As used in this section, the following word shall have the following meaning:
4382 "Psychotropic medication", a chemical substance that acts primarily upon the central nervous
4383 system where it alters brain function, resulting in temporary changes in perception, mood,
4384 consciousness and behavior.
4385 Every resident in a nursing home, rest home, or other long term care facility that is prescribed
4386 psychotropic medications, shall have the facility in which they reside, as well as the prescribing
4387 physician, first obtain informed consent from the resident, and the resident's health care proxy,
4388 or a court appointed Rogers guardian. The facility shall keep on record a copy of the written
4389 consent form between the resident and the prescribing physician when prescribing psychotropic
4390 medications.

4391 SECTION 234. Section 18 of chapter 15A of the General Laws, as appearing in the 2010 Official
4392 Edition, is hereby amended by striking out, in lines 14 and 36, the words "division of health care
4393 finance and policy" and inserting in place thereof, in each instance, the following words:-
4394 commonwealth health insurance connector.

4395

4396 SECTION 235. Section 64 of chapter 111 of the General Laws, as inserted by section 83 of this
4397 act, shall take effect on July 1, 2013.

4398 SECTION 236. Section 18 of chapter 15A of the General Laws, as appearing in the 2010 Official
4399 Edition, is hereby amended by striking out, in lines 14 and 36, the words "division of health care
4400 finance and policy" and inserting in place thereof, in each instance, the following words:-
4401 commonwealth health insurance connector.

4402 Section 237. Notwithstanding any law or regulation to the contrary, the division of insurance
4403 may report specific findings and legislative recommendations including the following: (1) the
4404 extent to which tiered products offerings have been adopted and utilized in the marketplace; (2)
4405 the extent to which tiered product offerings have reduced health care costs for both patients and
4406 employers; (3) the effects that tiered product offerings have on patient education relating to
4407 health care costs and quality; (4) the effects that tiered product offerings have on patient
4408 utilization of local hospitals and the resulting impact on overall state health care costs; (5)
4409 opportunities to incentivize tiered product offerings for both health systems and employers. The
4410 report shall be submitted to the Senate and House Committees on Ways and Means and the Joint
4411 Committee on Health Care Financing.
4412 SECTION 237A. Notwithstanding any provision of any general law or special law or regulation
4413 to the contrary, health care providers that receive written notice from the department of public
4414 health, prior to December 31, 2012, that they do not need a determination of need review for a
4415 project shall be exempt from needing to file a determination of need review at a later date if there
4416 project exceeds the newly established thresholds under Sections 37, 39 or 53 of this bill.
4417

4418 SECTION 237B. Notwithstanding the provisions of any general or special law or regulation to
4419 the contrary, the provisions of Section 25E ½ of Chapter 111 of the General Laws, as proposed
4420 to be added by Section 55, shall not apply to the review of an application for a determination of
4421 need that is filed with the department of public health under any applicable provision of Chapter
4422 111 of the General Laws on or before December 31, 2013.

4423 SECTION 238. To maximize the cost-effective and efficient use of nursing homes licensed
4424 under chapter 111, section 71 of the General Laws in the commonwealth's post-acute health care
4425 delivery system, the executive office of health and human services shall seek from the Secretary
4426 of the Department of Health and Human Services an exemption or waiver from the Medicare
4427 requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing facility be
4428 preceded by a three-day hospital stay.

4429 SECTION 239. Chapter 111 of the General Laws is hereby amended by inserting after section
4430 70G the following section:-

4431 Section 70H. Notwithstanding any provision in chapter 93A, sections 70E, 72E and 73 and 940
4432 CMR section 4.09, a facility or institution licensed by the department of public health under
4433 section 71 may move a resident to different living quarters or to a different room within the
4434 facility or institution if, as documented in the resident's clinical record and as certified by a
4435 physician, the resident's clinical needs have changed such that the resident either (1) requires
4436 specialized accommodations, care, services, technologies, staffing not customarily provided in
4437 connection with the resident's living quarters or room, or (2) ceases to require the specialized
4438 accommodations, care, services, technologies or staffing customarily provided in connection
4439 with the resident's living quarters or room; provided, however, that nothing in this section shall
4440 obviate a resident's notice and hearing rights when movement to different living quarters

4441 involves a resident moving from a Medicare-certified unit to a non-Medicare-certified unit or
4442 involves a resident moving from a non-Medicare-certified unit to a Medicare-certified unit and,
4443 provided, however, that the resident shall have the right to appeal to the facility's or institution's
4444 medical director a decision to move the resident to a different living quarter or to a different
4445 room within the facility or institution.

4446 Section 240. The department of public health shall amend their regulations regarding limited
4447 service clinics to allow such clinics to provide the following services to patients, provided that
4448 the limited service clinic only provides those services for which a patient's primary care provider
4449 has given written approval for prior to such care being administered:

4450 A) Monitoring and management of acute and chronic disease
4451 B) Wellness and preventive services

4452 Nothing in this section shall be interpreted to allow a limited service clinic to serve as a patient's
4453 primary care provider.

4454 SECTION 241. Section 2 of chapter 32A of the General Laws, as appearing in the 2010 Official
4455 Edition, is hereby amended by inserting after paragraph (h) the following paragraph:-

4456 (h 1/2) "Primary care provider", a health care professional qualified to provide general medical
4457 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
4458 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4459 maintains continuity of care within the scope of practice.

4460 SECTION 242. Section 22 of said chapter 32A, as so appearing, is hereby amended by striking
4461 out, in line 36, the word "physician" and inserting in place thereof the following word:- provider.

4462 SECTION 243. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby
4463 amended by inserting after the definition of “Net value of policies” the following definition:-

4464 “Primary care provider”, a health care professional qualified to provide general medical care for
4465 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
4466 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4467 maintains continuity of care within the scope of practice.

4468 SECTION 244. Section 47B of said chapter 175, as so appearing, is hereby amended by striking
4469 out, in line 46, the word “physician” and inserting in place thereof the following word:- provider.

4470 SECTION 245. Section 8A of chapter 176A of the General Laws, as so appearing, is hereby
4471 amended by striking out, in line 41, the word “physician” and inserting in place thereof the
4472 following word:- provider.

4473 SECTION 246. Subsection (c) of said section 8A of chapter 176A, as so appearing, is hereby
4474 amended by adding the following paragraph:-

4475 For the purposes of this subsection, the term “primary care provider” shall mean a health care
4476 professional qualified to provide general medical care for common health care problems who; (1)
4477 supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2)
4478 initiates referrals for specialist care; and (3) maintains continuity of care within the scope of
4479 practice.

4480 SECTION 247. Section 1 of chapter 176B of the General Laws, as so appearing, is hereby
4481 amended by inserting after the definition of “Participating optometrist” the following definition:-

4482 “Primary care provider”, a health care professional qualified to provide general medical care for
4483 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
4484 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4485 maintains continuity of care within the scope of practice.

4486 SECTION 248. Section 4A of said chapter 176B, as so appearing, is hereby amended by striking
4487 out, in line 43, the word “physician” and inserting in place thereof the following word:- provider.

4488 SECTION 249. Section 1 of chapter 176G of the General Laws, as so appearing, is hereby
4489 amended by inserting after the definition of “Person” the following definition:-

4490 “Primary care provider”, a health care professional qualified to provide general medical care for
4491 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
4492 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4493 maintains continuity of care within the scope of practice.

4494 SECTION 250. Section 4M of said chapter 176G, as so appearing, is hereby amended by
4495 striking out, in line 40, the word “physician” and inserting in place thereof the following word:-
4496 provider.

4497 SECTION 251. Section 1 of chapter 111 of the General Laws, as appearing in the 2010 official
4498 edition, is hereby amended by inserting after the definition of “Nuclear reactor” the following
4499 definition:-

4500 “Primary care provider”, a health care professional qualified to provide general medical care for
4501 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise

4502 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4503 maintains continuity of care within the scope of practice.

4504 SECTION 252. Section 67F of said chapter 111, as so appearing, is hereby amended by striking
4505 out, in lines 15 and 19, the word "physician" and inserting in place thereof the following word in
4506 each instance:- provider.

4507 SECTION 253. Section 7 of chapter 176O of the General Laws, as appearing in the 2010 Official
4508 Edition, is hereby amended by striking out, in line 48, the word "physician" and inserting in
4509 place thereof the following word:- provider.

4510 SECTION 254. Notwithstanding any general or special law to the contrary, section 2 of chapter
4511 112 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by
4512 adding, at the end thereof, the following sections: –
4513 Notwithstanding any other provisions of this chapter, the board may issue a telemedicine license
4514 to allow medical advice, diagnoses, treatments and prescriptions by physicians who hold a full
4515 and unrestricted medical license in a state other than Massachusetts. The board shall establish
4516 requirements for such licensure.
4517 A telemedicine license shall not be issued for a period that exceeds two years. A physician may
4518 seek renewal of a telemedicine license upon application and compliance with other requirements
4519 established by the board.

4520 SECTION 255. Section 8 of chapter 118E of the General Laws, as appearing in the 2010 Official
4521 Edition, is hereby amended by inserting after paragraph (e). the following paragraph:-

4522 (e1/2). "Primary care provider", a health care professional qualified to provide general medical
4523 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise

4524 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4525 maintains continuity of care within the scope of practice.

4526 SECTION 256. Section 17A of said chapter 118E, as so appearing, is hereby amended by
4527 striking out, in lines 60 and 62, the word “physician” and inserting in place thereof the following
4528 word in each instance:- provider.

4529 SECTION 257. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby
4530 amended by inserting after the definition of “Net value of policies” the following definition:-

4531 “Primary care provider”, a health care professional qualified to provide general medical care for
4532 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
4533 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4534 maintains continuity of care within the scope of practice.

4535 SECTION 258. Section 47U of said chapter 175, as so appearing, is hereby amended by striking
4536 out, in lines 62 and 64, the word “physician” and inserting in place thereof the following word in
4537 each instance:- provider.

4538 SECTION 259. Paragraph (a) of section 8U of chapter 176A, as so appearing, is hereby amended
4539 by inserting after the definition of “Insured” the following definition:-

4540 “Primary care provider”, a health care professional qualified to provide general medical care for
4541 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
4542 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4543 maintains continuity of care within the scope of practice.

4544 SECTION 260. Section 8U of said chapter 176A, as so appearing, is hereby amended by striking
4545 out, in lines 64 and 66, the word “physician” and inserting in place thereof the following word in
4546 each instance:- provider.

4547 SECTION 261. Section 1 of chapter 176B of the General Laws, as so appearing, is hereby
4548 amended by inserting after the definition of “Participating optometrist” the following definition:-

4549 “Primary care provider”, a health care professional qualified to provide general medical care for
4550 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
4551 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4552 maintains continuity of care within the scope of practice.

4553 SECTION 262. Section 4U of said chapter 176B, as so appearing, is hereby amended by striking
4554 out, in lines 64 and 66, the word “physician” and inserting in place thereof the following word in
4555 each instance:- provider.

4556 SECTION 263. Section 1 of chapter 176G of the General Laws, as so appearing, is hereby
4557 amended by inserting after the definition of “Person” the following definition:-

4558 “Primary care provider”, a health care professional qualified to provide general medical care for
4559 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
4560 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4561 maintains continuity of care within the scope of practice.

4562 SECTION 264. Section 5 of said chapter 176G, as so appearing, is hereby amended by striking
4563 out, in lines 59 and 61, the word “physician” and inserting in place thereof the following word in
4564 each instance:- provider.

4565 SECTION 265. Section 1 of Chapter 176O, as so appearing, he hereby amended by inserting
4566 after the definition of “Person” the following definition:-

4567 “Primary care provider”, a health care professional qualified to provide general medical care for
4568 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
4569 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
4570 maintains continuity of care within the scope of practice.

4571 SECTION 266. Section 20 of said chapter 176O, as so appearing, is hereby amended by striking
4572 out, in lines 19 and 22, the words “care physician” and inserting in place thereof the following
4573 words in each instance:- “care provider”

4574 SECTION 267. Section 5 of Chapter 112 of the General Laws is hereby amended by striking out
4575 paragraphs 6 through 8, inclusive, and inserting in place thereof the following four paragraphs: -

4576 The board shall collect the following information reported to it to create individual profiles on
4577 licensees and former licensees, in a format created by the board that shall be available for
4578 dissemination to the public:

4579 (a) a description of any criminal convictions for felonies and serious misdemeanors as
4580 determined by the board. For the purposes of this subsection, a person shall be deemed to be
4581 convicted of a crime if he pleaded guilty or if he was found or adjudged guilty by a court of
4582 competent jurisdiction;

4583 (b) a description of any charges for felonies and serious misdemeanors as determined by the
4584 board to which a physician pleads nolo contendere or where sufficient facts of guilt were found
4585 and the matter was continued without a finding by a court of competent jurisdiction;

4586 (c) a description of any final board disciplinary actions;

4587 (d) a description of any final disciplinary actions by licensing boards in other states;

4588 (e) a description of revocation or involuntary restriction of privileges by a hospital, clinic or
4589 nursing home under the provisions of chapter 111, or of any employer who employs physicians
4590 licensed by the board for the purpose of engaging in the practice of medicine in the
4591 commonwealth, for reasons related to competence or character that have been taken by the
4592 governing body or any other official of the hospital, clinic or nursing home or employer who
4593 employs physicians licensed by the board for the purpose of engaging in the practice of medicine
4594 in the commonwealth after procedural due process has been afforded, or the resignation from or
4595 nonrenewal of medical staff membership or the restriction of privileges at a hospital, clinic or
4596 nursing home or employer who employs physicians licensed by the board for the purpose of
4597 engaging in the practice of medicine in the commonwealth taken in lieu of or in settlement of a
4598 pending disciplinary case related to competence or character in that hospital, clinic or nursing
4599 home or of any employer who employs physicians licensed by the board for the purpose of
4600 engaging in the practice of medicine or employer who employs physicians licensed by the board
4601 for the purpose of engaging in the practice of medicine in the commonwealth ;

4602 (f) all medical malpractice court judgments and all medical malpractice arbitration awards in
4603 which a payment is awarded to a complaining party and all settlements of medical malpractice
4604 claims in which a payment is made to a complaining party. Dispositions of paid claims shall be
4605 reported in a minimum of three graduated categories indicating the level of significance of the
4606 award or settlement. Information concerning paid medical malpractice claims shall be put in
4607 context by comparing an individual licensee’s medical malpractice judgment awards and

4608 settlements to the experience of other physicians within the same specialty. Information
4609 concerning all settlements shall be accompanied by the following statement: “Settlement of a
4610 claim may occur for a variety of reasons which do not necessarily reflect negatively on the
4611 professional competence or conduct of the physician. A payment in settlement of a medical
4612 malpractice action or claim should not be construed as creating a presumption that medical
4613 malpractice has occurred.” Nothing herein shall be construed to limit or prevent the board from
4614 providing further explanatory information regarding the significance of categories in which
4615 settlements are reported.

4616 Pending malpractice claims shall not be disclosed by the board to the public. Nothing herein
4617 shall be construed to prevent the board from investigating and disciplining a licensee on the basis
4618 of medical malpractice claims that are pending.

4619 (g) names of medical schools and dates of graduation;

4620 (h) graduate medical education;

4621 (i) specialty board certification;

4622 (j) number of years in practice;

4623 (k) names of the hospitals where the licensee has privileges;

4624 (l) appointments to medical school faculties and indication as to whether a licensee has a
4625 responsibility for graduate medical education within the most recent ten years;

4626 (m) information regarding publications in peer-reviewed medical literature within the most
4627 recent ten years;

4628 (n) information regarding professional or community service activities and awards;

4629 (o) the location of the licensee's primary practice setting;

4630 (p) the identification of any translating services that may be available at the licensee's primary
4631 practice location;

4632 (q) an indication of whether the licensee participates in the medicaid program.

4633 The board shall provide individual licensees with a copy of their profiles prior to release to the
4634 public. A licensee shall be provided a reasonable time to correct factual inaccuracies that appear
4635 in such profile

4636 A physician may elect to have his profile omit certain information provided pursuant to clauses
4637 (l) to (n), inclusive, concerning academic appointments and teaching responsibilities, publication
4638 in peer-reviewed journals and professional and community service awards. In collecting
4639 information for such profiles and in disseminating the same, the board shall inform physicians
4640 that they may choose not to provide such information required pursuant to said clause (l) to (n),
4641 inclusive.

4642 For physicians who are no longer licensed by the board, the board shall continue to make
4643 available the profiles of such physicians, except for those who are known by the board to be
4644 deceased. The board shall maintain the information contained in the profiles of physicians no
4645 longer licensed by the board as of the date the physician was last licensed, and include on the
4646 profile a notice that the information is current only to that date.

4647 SECTION 268. Notwithstanding any general or special law or rule or regulation to the contrary,
4648 all orders, rules and regulations duly made and all approvals duly granted by the transferor

agency, the division of health care finance and policy, in relation to section 18 of chapter 15A, sections 6C and 18B of chapter 118G and section 188 of chapter 149 of the General Laws, 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, the commonwealth health insurance connector.