HOUSE . . . . No. 4070

The Commonwealth of Massachusetts

HOUSE, May 04, 2012

By Mr. Walsh of Lynn, for the committee on Health Care Financing, on Senate, Nos. 483, 485, 486, 487, 502, 505, 508, 523, 525, 533, 538, 541, 542, 543, 552 and 555 and House, Nos. 339, 341, 345, 628, 1220, 1221, 1222, 1225, 1236, 1237, 1240, 1498, 2081, 2084, 2085, 2093, 2098, 2100, 2781, 2784, 2785, 3354 and 3614, a Bill relative to health care quality improvement and cost reduction act of 2012 (House, No. 4070). May 7, 2012.

For the committee,

STEVEN M. WALSH.

HOUSE . . . . No. 4070

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

An Act relative to Health Care Quality Improvement and Cost Reduction Act of 2012.

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

1 SECTION 1. Sections 16J to 16L, inclusive, of chapter 6Aof the General Laws, as appearing in
2 the 2010 Official Edition, are hereby repealed.

3 SECTION 2. The chapter 10 of the General Laws, as so appearing, is hereby amended by adding
4 after section 74 the following section:—

5 Section 75. There shall be established and set up on the books of the commonwealth a Wellness
6 and Prevention Trust Fund to promote wellness at the community level in partnership with
7 clinical providers within a certain geographic area. The fund shall consist of revenues collected
8 by the commonwealth: (1) any fines and penalties allocated to the fund under the General Laws;
9 and (2) from public and private sources as gifts, grants and donations.

10 All revenues credited under this section shall remain in the Wellness and Prevention Trust Fund,
11 not subject to appropriation, to be expended by the department of public health on wellness and
12 prevention activities linked to clinical care and population-based public health needs. The state
13 treasurer shall not deposit or otherwise transfer the revenues to the General Fund or any other
14 fund.

15 The state treasurer shall deposit the moneys in the fund in accordance with section 34 of chapter
16 29 in a manner that will secure the highest interest available consistent with the safety of the
17 fund and with the requirement that all amounts on deposit shall be available for immediate
18 withdrawal at all times. The fund shall be expended at the direction of the commissioner of
19 public health only for the purposes stated in this section and any unexpended balances in the
20 fund at the end of the fiscal year shall not revert to the general fund and shall be available for
21 expenditures in the subsequent fiscal year.

22 SECTION 3. Chapter 12 of the General Laws, as so appearing, is hereby amended by inserting
23 after section 11L the following section:—

24 Section 11M. As used in this section, terms shall have the meanings assigned by section 1 of
25 chapter 118G.

26 The attorney general shall:

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

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

35 (c) provide assistance as needed to support efforts by the commonwealth to obtain waivers from
36 certain provisions of federal law including, from the federal office of the inspector general, a
37 waiver of the provisions of, or expansion of the "safe harbors" provided for under 42 U.S.C.
38 section 1320a-7b; and a waiver of the provisions of 42 U.S.C. section 1395nn(a) to (e).

39 SECTION 4. Section 7A of chapter 26, as so appearing, is hereby amended by inserting at the
40 end, the following paragraph:—

41 The division shall create a model wellness guide for payers, employers and consumers. The
42 guide shall provide the following information: 1) the importance of healthy lifestyles, disease
43 prevention, the benefits of care management, and health promotion; 2) financial and other
44 incentives for participating in wellness programs; 3) explanation of the use of technology to
45 provide wellness information and services; 4) the benefits of participating in tobacco cessation
46 programs, weight loss programs, and compliance with disease management; 5) a description of
47 the discounts available to employees under the Affordable Care Act; and 6) the ability for payers
48 to reduce premiums by offering incentives to patients with chronic diseases or high-risk of
49 hospitalization to better comply with prescribed drugs and follow up care.

50 In developing the model guide, the division shall consult with department of public health and
51 health care stakeholders, including but not limited to employers, including representatives of
52 employers 50 employees or more and representatives of employers with less than 50 employees;
53 providers, both for profit and not for profit; health plans and public payers; researchers;
54 consumers; and government.

55 SECTION 5. Chapter 29 of the General Laws, as so appearing, is hereby amended by inserting
56 after section 2BBBB the following 2 sections:—

57 Section 2CCCC. (a)There is hereby established and set up on the books of the commonwealth a
58 separate fund to be known as the Health Care Workforce Trust Fund, hereinafter called the fund.
59 The fund shall be administered by the health care workforce center which may contract with any
60 appropriate entity to administer the fund or any portion therein. The purposes of the fund shall
61 include: (i) making awards to health professionals for repayment assistance for medical or
62 nursing school loans pursuant to section 62 of chapter 118G , provided that in administering the
63 loan forgiveness grant program, a portion of funds therein shall be granted to applicants
64 performing terms of service in rural primary care sites that meet the criteria of a medically
65 underserved area as determined by the health care workforce center; (ii providing employment
66 training opportunities, job placement, career ladder and educational services for currently
67 employed or unemployed health workers who are seeking new positions or responsibilities
68 within the health care industry with a focus on aligning training and education with industry
69 needs, provided that the fund shall support the distribution of grants to selected health systems,
70 non-profit organizations, labor unions, labor-industry partnerships and others; (iii) funding
71 residency positions in primary care pursuant to section 64 of chapter 118G; and (iv) funding
72 rural health rotation programs, rural health clerkships, and rural health preceptorships at medical
73 and nursing schools to expose students to practicing in rural and small town communities.

74 (b) There shall be credited to the fund all monies payable pursuant to (i) funds that are paid to the
75 health care workforce loan repayment program, established under section 62 of chapter 118G, as
76 a result of a breach of contract and private funds contributed from other sources; and (ii) any
77 revenue from appropriations or other monies authorized by the general court and specifically
78 designated to be credited to the fund, and any gifts, grants, private contributions, investment

79 income earned on the fund's assets and all other sources. Money remaining in the fund at the end
80 of a fiscal year shall not revert to the General Fund.

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

83 (d) The division of health care cost and quality shall promulgate regulations pursuant to the
84 distribution of monies from the fund to programs listed under subsection (a) and applicant
85 eligibility criteria for said funds.

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

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

97 The division, in consultation with the Massachusetts Hospital Association, shall develop a
98 competitive grant process for awards to be distributed to distressed hospitals out of said fund.
99 The grant process shall consider the following factors, including but not be limited to (1) payer
100 mix, (2) financial health, (3) geographic need, and (4) population need.

101 SECTION 6. Chapter 32A of the General Laws, as so appearing, is hereby amended by inserting
102 after section 26 the following 3 sections:-

103 Section 27. Pursuant to section 50 of chapter 118G, the commission shall provide a toll-free
104 number and website that enables consumers to request and obtain from the commission in real
105 time the maximum estimated amount the insured will be responsible to pay for a proposed
106 admission, procedure or service that is a medically necessary covered benefit, based on the
107 information available to the carrier at the time the request is made, including any copayment,
108 deductible, coinsurance or other out of pocket amount and the actual or maximum estimated
109 allowed amount, for any health care benefits.

110 As used in this section, "allowed amount" shall mean the contractually agreed upon amount paid
111 by a carrier to a health care provider for health care services provided to an insured.

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

113 Section 29. Pursuant to section 50 of chapter 118G, the commission shall disclose patient-level
114 data including, but not limited to, health care service utilization, medical expenses,
115 demographics, and where services are being provided, to all providers in their network, provided
116 that data shall be limited to patients treated by that provider, in order to aid providers in
117 managing the care of their own patient panel.

118 SECTION 7. Chapter 32B of the General Laws, as so appearing, is hereby amended by inserting
119 after section 20 the following 3 sections:-

120 Section 21. Pursuant to section 50 of 118G, every appropriate public authority which has
121 accepted this chapter shall provide a toll-free number and website that enables consumers to

122 request and obtain from the public authority in real time the maximum estimated amount the
123 insured will be responsible to pay for a proposed admission, procedure or service that is a
124 medically necessary covered benefit, based on the information available to the carrier at the time
125 the request is made, including any copayment, deductible, coinsurance or other out of pocket
126 amount for any health care benefits.

127 Section 22. Every appropriate public authority which has accepted this chapter shall attribute
128 every member to a primary care provider.

129 Section 23. Pursuant to section 50 of chapter 118G, every appropriate public authority which has
130 accepted this chapter shall disclose patient-level data including, but not limited to, health care
131 service utilization, medical expenses, demographics, and where services are being provided, to
132 all providers in their network, provided that data shall be limited to patients treated by that
133 provider, so as to aid providers in managing the care of their own patient panel.

134 SECTION 8. Sections 6D, 6E, 6F and 6G of chapter 40J of the General Laws, as so appearing,
135 are hereby repealed.

136 SECTION 9. Section 6 of chapter 62 of the General Laws, as so appearing, is hereby amended
137 by inserting after subsection (q) the following subsection:—

138 (r) (1) An employer subject to tax under this chapter which participates in a wellness
139 program may take a credit against the excise imposed under this chapter in an amount equal to
140 25 percent of the costs associated with implementing the plan, with a maximum credit of
141 $10,000.

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

146 SECTION 10. Chapter 63 of the General Laws, as so appearing, is hereby amended by inserting
147 after section 38BB the following section:—

148 Section 38CC. (a) A corporation subject to tax under this chapter which participates in a wellness
149 program may take a credit against the excise imposed under this chapter in an amount equal to
150 25% of the costs associated with the implementing the plan, with a maximum of $10,000.

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

155 SECTION 11. Section 1 of chapter 111, as so appearing, is hereby amended by inserting before
156 the definition of "Board of health", the following definition:-

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

159 SECTION 12. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby
160 amended by striking out, in line 38, the words "one hundred and seventy-six G" and inserting in
161 place thereof the following words:- 176G or within an accountable care organization licensed by
162 the division of health care cost and quality under chapter 118J.

163 SECTION 13. Sections 25L through 25N, inclusive, of chapter 111, as so appearing, are hereby
164 repealed.

165 SECTION 14. Section 25P is Chapter 111, as so appearing, is hereby repealed.

166 SECTION 15. Section 51H of chapter 111, as so appearing, is hereby amended by striking
167 subsection (c) and inserting in place thereof the following subsection:—

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

175 SECTION 16. Chapter 111 is hereby amended by inserting after section 51H the following new
176 section:-

177 Section 51I. Separate negotiations for health care providers

178 (a) As used in this section, the following words shall have the following meanings: --

179 “Facility”, any hospital, as defined in section 52 of chapter 111 of the General Laws, or clinic
180 conducted by a hospital, as licensed under section 51 of chapter 111, which receives a separate
181 on-site review survey by the Joint Commission on the Accreditation of Healthcare Organization.

182 (b) Public and private payers shall negotiate separate contracts for each facility, regardless of
183 affiliation with a system or ownership by a system.

184 (c) Each facility within a larger system shall establish separate negotiating teams.

185 (d) Every facility must establish a firewall mechanism that prevents the separate contract
186 negotiating teams from sharing any information that would inhibit them from competing with
187 each other and with other hospitals and physician practice groups.

188 (e) Contracts may not be contingent on entering into a contract with another health care provider
189 within a system.

190 (f) Contracts may not make the availability of any price or term for a contract contingent on
191 entering into a contract with another health care facility.

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

193 (h) The Department and the Office of the Attorney General shall have the authority to enforce
194 the requirements of this section.

195 (i) If a system has entered into alternative payment methodology contracts with a carrier and
196 more than 50 per cent of their patients are covered under alternative payment methodology
197 contracts, then they shall be exempt from the requirements of this section.

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

200 SECTION 17. Said chapter 111 is hereby amended by inserting after section 53G the following
201 section:—

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

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

205 (1) to develop and administer a program for certification of physician organizations including,
206 but not limited to establishing levels of certification, designing standards for practice to increase
207 the transparency, and improving the functioning of the health care system;

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

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

213 (4) to establish and implement procedures for the review, investigation, resolution, or referral to
214 the appropriate provider licensing entity of such complaints involving certified physician
215 organizations, including appropriate disciplinary actions available to the division in connection
216 with complaint resolution, which may include a fine, or suspension, revocation, or denial of a
217 certificate, or a combination of the foregoing, and to discipline certificate holders in accordance
218 with procedures established by the division that shall conform with chapter 30A and 801 CMR
219 1.01 et seq.;

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

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

223 (c) A physician organization shall be defined as a group of physicians contracting as a single
224 entity rather than in their individual capacities unless the group consists of 9 physicians or fewer.

225 Provided however that any licensed entity including, but not limited to hospitals and clinics that
226 directly employ physicians shall not be required to register as a physician organizations.

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

229 (e) Within 45 days of receipt of a complete application, the division shall complete its review of
230 the application and send written notice to the physician or physician organization, with a copy to
231 the division of insurance, explaining its decision to: (1) issue the certification as applied for; (2)
232 issue the certification as applied for but with conditions that restrict certain material changes
233 without prior approval; (3) issue a certification at a lower certification level than applied for; (4)
234 reject the application for failure to comply with the requirements of the application process, with
235 instructions that the application may be resubmitted within 10 days; or (5) deny the application.

236 (f) Any physician organization whose application has been rejected or denied, or who has been
237 issued a certificate with conditions or at a lower level than applied for, may request an
238 adjudicatory hearing pursuant to chapter 30A within 21 days of the division's decision. The
239 division shall notify the attorney general and the division of insurance upon receipt of such
240 hearing request. Said hearing shall be conducted within 30 days of the division's receipt of the
241 hearing request. The attorney general may intervene in a hearing under this subsection and may
242 require the production of additional information or testimony. The commissioner shall issue a
243 written decision within 30 days of the conclusion of the hearing.

244 (g) A physician organization aggrieved by said written decision may, within 20 days of said
245 decision, file a petition for review in the Suffolk superior court. Review by the supreme judicial

246 court on the merits shall be limited to the record of the proceedings before the commissioner and
247 shall be based upon the standards set forth in paragraph (7) of section 14 of chapter 30A.

248 SECTION 18. Chapter 111 of the General Laws is hereby amended by inserting after section 206
249 the following section:-

250 Section 206A. The commissioner shall provide a wellness seal of approval to a wellness program
251 that is actuarially equivalent to the programs defined in section 206 of this chapter. The
252 commissioner, in consultation with the commissioner of the department of revenue, shall create
253 the appropriate form for showing that an employer is using an approved wellness program.

254 SECTION 19. Section 217 of said chapter 111, as so appearing, is hereby repealed

255 SECTION 20. Said chapter 111, as so appearing, is hereby amended by inserting after section
256 224 the following 2 sections:—

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

262 (b) A health care provider referring a patient to another provider that is part of or represented by
263 the same provider organization as defined in section 53H shall disclose (i) that the providers are
264 part of or represented by the same provider organization, and upon the request by the patient, (ii)
265 the charges, and if available, the allowed amount, or where it is not possible to quote a specific
266 amount in advance due to the health care provider's inability to predict the specific treatment or

267 diagnostic code, the estimated charges or estimated allowed amount for a proposed admission,
268 procedure or service.

269 As used in this section, "allowed amount", shall mean the contractually agreed upon amount paid
270 by a carrier to a health care provider for health care services provided to an insured.

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

273 "Hospital", a hospital licensed under section 51 of chapter 111, the teaching hospital of the
274 University of Massachusetts medical school, a licensed private or state-owned and state-operated
275 general acute care hospital, or an acute care unit within a state-operated facility; provided,
276 however, that "hospital" shall not include a licensed non-acute care hospital classified as an
277 inpatient rehabilitation facility, an inpatient substance abuse facility, or a long term care hospital
278 by the federal Centers for Medicare and Medicaid Services.

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

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

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

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

293 (d) The department of public health in consultation with the Massachusetts Nurses Association
294 and the Massachusetts Hospital Association, and other organizations, shall determine what
295 constitutes an "emergency situation." The department shall solicit feedback through public
296 hearing. The department of public health on or before February 1, 2013 shall promulgate
297 regulations or guidelines to implement the findings of this section.

298 (e) Beginning April 15, 2013, hospitals shall report all instances of mandatory overtime, and the
299 circumstances requiring its use, to the department of public health. Such reports shall be public
300 documents.

301 (f) The department of public health on or before January 1, 2014 shall promulgate regulations to
302 establish a system to levy an administrative fine on any facility that violates this act or any
303 regulation issued under this act. The fine shall be not less than $100 and not greater than $1,000
304 for each violation and fines collected shall be dedicated to the department of public health's
305 statewide sexual assault nurse examiner program. Said regulations shall also establish an
306 independent appeals process for penalized entities.

307 (g) A nurse shall not be allowed to exceed sixteen consecutive hours worked in a twenty-four
308 hour period. In the event a nurse works sixteen consecutive hours, said nurse must be given at
309 least eight consecutive hours of off-duty time immediately after the worked overtime.

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

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

318 SECTION 21. Section 2 of chapter 112 of the General Laws, as so appearing, is hereby amended
319 by inserting the following after the second sentence of the first paragraph:—The board shall
320 require, as a standard of eligibility for licensure, that applicants demonstrate proficiency in the
321 use of computerized physician order entry, e-prescribing, electronic health records and other
322 forms of health information technology, as determined by the board. As used in this section,
323 proficiency, at a minimum shall mean that applicants demonstrate the skills to comply with the
324 "meaningful use" requirements, so-called, as set forth in 45 C.F.R. Part 170.

325 SECTION 22. Said chapter 112, as so appearing, is hereby amended by inserting after section
326 2C, the following section:—

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

331 SECTION 23. Section 9C of chapter 112 of the General Laws, as so appearing, is hereby
332 amended by striking the definition of "physician assistant" and inserting in place thereof the
333 following definition:-

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

335 SECTION 24. Section 9E of chapter 112 of the General Laws, as so appearing, is hereby
336 amended by striking out, in lines 5 and 6, the words "A registered physician shall supervise no
337 more than 4 physician assistants at any one time.".

338 SECTION 25. Said section 9E, as so appearing, is hereby amended by striking out, in lines 15
339 through 17, the words "Any prescription of medication made by a physician assistant must
340 include the name of the supervising physician.".

341 SECTION 26. Chapter 112 of the General Laws is hereby amended by inserting after section
342 80H the following section:—

343 Section 80I. When a provision of law or rule requires a signature, certification, stamp,
344 verification, affidavit or endorsement by a physician, when relating to physical or mental health,
345 that requirement may be fulfilled by a nurse practitioner practicing under section 80B of chapter
346 112. Nothing in this section shall be construed to expand the scope of practice of nurse
347 practitioners. This section shall not be construed to preclude the development of mutually
348 agreed upon guidelines between the nurse practitioner and supervising physician under section
349 80E of chapter 112.

350 SECTION 27. Chapter 118E of the General Laws, as so appearing, is hereby amended by adding
351 the following 8 sections:—

352 Section 63. In connection with the governor's fiscal year 2015 budget recommendation, the
353 secretary of administration and finance and the director of Medicaid shall submit to the
354 legislature a plan to ensure greater predictability and stability in the rates paid by Medicaid to
355 health care providers. The plan shall include the establishment of a Medicaid reserve fund or a
356 similar mechanism that will allow the office of Medicaid to establish rates paid to providers at
357 least 12 months prior to the time such rates take effect.

358 Section 64. As of July 1, 2013, rates paid by Medicaid to acute care hospitals and to providers of
359 primary care services shall increase by 2 percent, provided, however, that only those hospitals
360 and providers that have demonstrated to the satisfaction of the division of health care cost and
361 quality a significant transition to the use of alternative payment methodologies shall be eligible
362 for the increased payment rate. The division shall establish by regulation what constitutes a
363 significant use of alternative payment methodologies by a provider. The increase in Medicaid
364 rates provided for in this section shall not be included in the calculation of state wide health care
365 cost growth targets under section 46 of chapter 118G.

366 Section 65. During fiscal year 2013, the office of Medicaid shall develop an accountable care
367 organization and patient-centered medical home innovation project that employs alternative
368 payment methodologies including but not limited to bundled payments, global payments, shared
369 savings and accountability for downstream spending and other innovative methods of paying for
370 health care services. The office of Medicaid shall take actions necessary to amend its managed
371 care organization and primary care clinician contracts as necessary to include such contracts in
372 the innovation project.

373 Section 66. To the greatest extent possible, the office of Medicaid shall pay for health care using
374 the accountable care organization, or patient-centered medical home model of delivering health
375 care services. In making the transition to ACOs and patient-centered medical homes, the office
376 of Medicaid shall achieve the following benchmarks:

377 (i) By January 1, 2013, the office of Medicaid must pay for health care based on the ACO or
378 medical home health care delivery model for at least 25 percent of its enrollees.

379 (ii) By January 1, 2014, the office of Medicaid must pay for health care based on the ACO or
380 medical home health care delivery model for at least 50 percent of its enrollees.

381 (iii) By January 1, 2015, the office of Medicaid must pay for health care based on the ACO or
382 medical home health care delivery model for at least 80 percent of its enrollees.

383 Section 67. To the extent that the office of Medicaid continues to pay acute care hospitals and
384 other providers on a fee-for-service basis, the office shall establish, in cases in which the office
385 believes it would enhance the health care quality and spending control objectives of this act, a
386 shared savings payment program. Under such a program, if a provider is paid on a fee-for-
387 service basis and the provider's total reimbursements have increased at a rate lower than the
388 health care cost growth benchmarks established in section 46 of chapter 118G, such provider
389 shall receive a share of the savings and the remainder of the savings shall be retained by the
390 commonwealth. If a provider is paid on a fee-for-service basis and the provider's total
391 reimbursements have increased at a rate greater than the health care cost growth benchmarks
392 established in section 46 of chapter 118G, the commonwealth shall pay a share of the excess of
393 the rate of growth in such fees above the applicable cost growth benchmark and the remainder
394 shall be borne by the provider.

395 Section 68. MassHealth shall implement no later than July 1, 2013 the Express Lane re-
396 enrollment program for streamlined eligibility procedures to renew eligibility for parents with
397 children who are enrolled in the SNAP program.

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

406 Section 70. The division of medical assistance shall attribute every member to a primary care
407 provider.

408 SECTION 28. Section 1 of chapter 118G, as so appearing, is hereby amended by striking out
409 said section in its entirety and inserting in place thereof the following:—

410 As used in this chapter, the following words shall, unless the context clearly requires otherwise,
411 have the following meanings:—

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

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

418 “Accountable care organization” or “ACO”, means an accountable care organization licensed
419 under chapter 118J.

420 “ACO Participant”, a health care provider that either integrates or contracts with an ACO to
421 provide services to ACO patients.

422 “ACO Patient”, an individual who chooses or is attributed to an ACO for his course of medical
423 treatment, for whom such services are paid by the payer to the ACO.

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

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

428 “Alternative payment contract”, an agreement between a payer and an ACO or other provider in
429 which reimbursement available under the agreement is pursuant to an alternative payment
430 methodology, as defined in this chapter, for services provided by an ACO or other provider. The
431 contract shall include at least some performance based quality measures with associated financial
432 rewards or penalties, or both.

433 “Alternative payment methodologies or methods”, methods of payment that compensate ACOs
434 and other providers for the provision of health care services, including but not limited to shared
435 savings arrangements, bundled payments for acute care episodes, bundled payments for chronic

436 diseases, and global payments, as defined in regulations adopted by the division. Alternative
437 payment methodologies shall include a risk adjustment for health status. No payment based on
438 the fee-for-service methodology shall be considered an alternative payment.

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

442 "Ambulatory surgical center services", services described for purposes of the Medicare program
443 pursuant to 42 USC § 1395k(a)(2)(F)(I). These services include facility services only and do not
444 include surgical procedures.

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

450 "Bundled payment for acute care episode," a single payment for the estimated cost of all the
451 services, either inpatient or outpatient, associated with clinically defined episode of care, which
452 may include, but not be limited to follow-up care or rehabilitation services.

453 "Bundled payment for chronic diseases," a single payment for the care of a chronic disease that
454 includes all physician, clinic, inpatient and outpatient services related to that condition for a
455 specified period of time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

509 “Free care”, the following medically necessary services provided to individuals determined to be
510 financially unable to pay for their care, in whole or in part, pursuant to applicable regulations of
511 the division: (1) services provided by acute hospitals; (2) services provided by community health
512 centers; and (3) patients in situations of medical hardship in which major expenditures for health
513 care have depleted or can reasonably be expected to deplete the financial resources of the
514 individual to the extent that medical services cannot be paid, as determined by regulations of the
515 division.

516 “General health supplies, care or rehabilitative services and accommodations”, all supplies, care
517 and services of medical, optometric, dental, surgical, podiatric, psychiatric, therapeutic,
518 diagnostic, rehabilitative, supportive or geriatric nature, including inpatient and outpatient
519 hospital care and services, and accommodations in hospitals, sanatoria, infirmaries, convalescent
520 and nursing homes, retirement homes, facilities established, licensed or approved pursuant to the
521 provisions of chapter 111B and providing services of a medical or health-related nature, and
522 similar institutions including those providing treatment, training, instruction and care of children
523 and adults; provided, however, that rehabilitative service shall include only rehabilitative
524 services of a medical or health-related nature which are eligible for reimbursement under the
525 provisions of Title XIX of the Social Security Act.

526 “Global payment,” a fixed-dollar payment for the care that patients may receive in a specified
527 period of time and that places providers at financial risk for both the occurrence of medical
528 conditions as well as the management of those conditions. Global payments may include both
529 primary and specialty care.

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

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

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

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

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

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

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

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

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

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

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

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

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

569 “Hospital”, any hospital licensed under section 51 of chapter 111, the teaching hospital of the
570 University of Massachusetts Medical School and any psychiatric facility licensed under section
571 19 of chapter 19.

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

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

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

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

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

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

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

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

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

599 “Non-providing employer”, an employer of a state-funded employee, as defined in this section;

600 provided, however, that the term “non- providing employer” shall not include:—

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

602 (ii) an employer that is signatory to or obligated under a negotiated, bona fide collective

603 bargaining agreement between such employer and bona fide employee representative which

604 agreement governs the employment conditions of such person receiving free care;

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

606 (iv) an employer that employs not more than 10. For the purposes of this definition, an employer

607 shall not be considered to pay for or arrange for the purchase of health care services provided by

608 acute hospitals and ambulatory surgical centers by making or arranging for any payments to the

609 uncompensated care pool.

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

611 “Patient-centered medical home”, a model of health care delivery designed to provide a patient

612 with a single point of coordination for all their health care, including primary, specialty, post-

613 acute and chronic care, which is (a) patient-centered; (b) comprehensive, integrated and

614 continuous; and (c) delivered by a team of health care professionals to manage a patient’s care,

615 reduce fragmentation, and improve patient outcomes.

616 “Payer”, any entity, other than an individual, that pays providers for the provision of health care

617 services. It shall include both governmental and private entities, but excludes ERISA plans.

618 “Payments from non-providing employers”, all amounts paid to the Uncompensated Care Trust

619 Fund or the General Fund or any successor fund by non-providing employers.

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

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

628 “Per capita total medical expense“, the total cost of care provided in Massachusetts to
629 Massachusetts residents, expressed on a per member per year basis, as calculated under section
630 46 and the regulations promulgated by the division. This measure excludes expenses paid for
631 entirely without insurance or through a supplemental insurance policy that is not the primary
632 policy for purposes of minimum creditable coverage requirements as defined by the
633 commonwealth connector authority.

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

638 “Performance penalty”, an amount paid by an provider to a payer or a reduction in the payments
639 made by a payer to a provider for failing to achieve certain quality measures as herein defined.
640 Performance penalty provisions and their implementation shall comply with this chapter, any
641 regulations of the division, and the contract between a provider and a payer.

642 “Potential gross state product”, the gross state product

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

644 “Primary Care Physician”, a physician who has a primary specialty designation of internal
645 medicine, general practice, family practice, pediatric practice or geriatric practice.

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

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

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

659 “Provider organizations”, shall mean a provider organization certified under section 53H of
660 chapter 111.

661 “Public health care payer”, the Medicaid program established in chapter 118E; any carrier or
662 other entity that contracts with the office of Medicaid or the commonwealth health insurance

663 connector to pay for or arrange the purchase of health care services on behalf of individuals
664 enrolled in health coverage programs under Titles XIX or XXI, or under the commonwealth care
665 health insurance program, including prepaid health plans subject to the provisions of section 28
666 of chapter 47 of the acts of 1997; the group insurance commission established under chapter
667 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

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

670 "Public payer-dependent non-acute hospital", any non-acute hospital that (1) was certified by the
671 Secretary of the United States Department of Health and Human Services as participating in the
672 federal medicare program pursuant to clause (iv) of 42 USC section 1395ww (d)(1)(B) on
673 January 1, 1996; (2) is not owned by the commonwealth; and (3) exhibits a payor mix in which a
674 minimum of 15 per cent of such hospital's gross patient service revenue, as reported on the RSC-
675 403 for hospital fiscal year 1994, was attributable to Title XIX of the federal Social Security Act.
676 Such term does not include a hospital that was reimbursed for services provided to individuals
677 entitled to medical assistance under chapter 118E for fiscal year 1996 pursuant to a contract
678 between the hospital and the division of medical assistance.

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

681 "Quality measures", the standard quality measure set as defined by the division in section 68.

682 "Relative prices", the contractually negotiated amounts paid to providers by each private and
683 public carrier for health care services, including non-claims related payments and expressed in

684 the aggregate relative to the payer's network-wide average amount paid to providers, as
685 calculated under section 6 of chapter 118G and regulations promulgated by the commissioner.

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

688 "Resident", a person living in the commonwealth, as defined by the division by regulation;
689 provided, however, that such regulation shall not define a resident as a person who moved into
690 the commonwealth for the sole purpose of securing health insurance under this chapter.
691 Confinement of a person in a nursing home, hospital or other medical institution shall not in and
692 of itself, suffice to qualify such person as a resident.

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

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

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

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

700 "Small business", a business in which the total number of full-time employees, when averaged
701 on an annual basis, does not exceed fifty, including only of the self-employed.

702 "Social service program", a social, mental health, mental retardation, habilitative, rehabilitative,
703 substance abuse, residential care, adult or adolescent day care, vocational, employment and
704 training, or elder service program or accommodations, purchased by a governmental unit or

705 political subdivision of the executive office of health and human services, but excluding any
706 program, service or accommodation that: (a) is reimbursable under a Medicaid waiver granted
707 under section 1115 of Title XI of the Social Security Act; or (b) is funded exclusively by a
708 federal grant.

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

710 “Sole community provider”, any acute hospital which qualifies as a sole community provider
711 under medicare regulations or under regulations promulgated by the division, which regulations
712 shall consider factors including, but not limited to, such as isolated location, weather conditions,
713 travel conditions, percentage of Medicare, Medicaid and free care provided and the absence of
714 other reasonably accessible hospitals in the area. Such hospitals shall include those which are
715 located more than twenty-five miles from other such hospitals in the commonwealth and which
716 provide services for at least sixty percent of their primary service area.

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

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

727 “State institution”, any hospital, sanatorium, infirmary, clinic and other such facility owned,

728 operated or administered by the commonwealth, which furnishes general health supplies, care or

729 rehabilitative services and accommodations.

730 “Third party administrator”, an entity that administers payments for health care services on

731 behalf of a client in exchange for an administrative fee.

732 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX programs,

733 other governmental payers, insurance companies, health maintenance organizations and

734 nonprofit hospital service corporations. Third party payer shall not include a purchaser

735 responsible for payment for health care services rendered by a hospital, either to the purchaser or

736 to the hospital.

737 “Title XIX,” Title XIX of the Social Security Act, 42 USC 1396 et seq., or any successor statute

738 enacted into federal law for the same purposes as Title XIX.

739 “Uninsured patient”, a patient who is not covered by a health insurance plan, a self-insurance

740 health plan, or a medical assistance program.

741 SECTION 29. Section 2 of chapter 118G as so appearing is hereby amended by striking out said

742 section in its entirety and inserting in place thereof the following:—

743 Section 2. (a) There shall be a body politic and corporate and a public instrumentality to be

744 known as the division of health care cost and quality, which shall be an independent public entity

745 not subject to the supervision and control of any other executive office, department, commission,

746 board, bureau, agency or political subdivision of the commonwealth except as specifically

747 provided in any general or special law. The exercise by the division of the powers conferred by

748 this chapter shall be considered to be the performance of an essential public function.

749 (b) There shall be a board, with duties and powers established by this chapter, that shall govern

750 the division. The board shall consist of 9 members: the secretary of administration and finance,

751 ex officio; the secretary of health and human services, ex officio; the secretary of housing and

752 economic development, ex officio; 2 members appointed by the governor, 1 of whom shall be a

753 health care economist and 1 of whom shall be a primary care provider licensed to practice in the

754 commonwealth; 2 members appointed by the attorney general, 1 of whom shall be a practicing

755 nurse licensed to practice in the commonwealth and 1 of whom shall be shall be an expert in a

756 health care consumer advocacy and privacy protection; 2 members appointed by the state

757 auditor, 1 of whom shall be an expert in health care administration and finance and 1 of whom

758 shall be an expert in hospital administration and finance. The governor shall designate the

759 chairperson of the board. All appointments shall serve a term of 3 years, but a person appointed

760 to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall

761 be eligible for reappointment. The board shall annually elect 1 of its members to serve as vice-

762 chairperson. Each member of the board serving ex officio may appoint a designee under section

763 6A of chapter 30.

764 (c) Five members of the board shall constitute a quorum, and the affirmative vote of 5 members

765 of the board shall be necessary and sufficient for any action taken by the board. No vacancy in

766 the membership of the board shall impair the right of a quorum to exercise all the rights and

767 duties of the division. Members shall serve without pay, but shall be reimbursed for actual

768 expenses necessarily incurred in the performance of their duties.

769 (d) Any action of the division may take effect immediately and need not be published or posted
770 unless otherwise provided by law. Meetings of the division shall be subject to sections 18
771 through 25, inclusive, of chapter 30A; but, said sections shall not apply to any meeting of
772 members of the division serving ex officio in the exercise of their duties as officers of the
773 commonwealth if no matters relating to the official business of the division are discussed and
774 decided at the meeting. The division shall be subject to all other provisions of said chapter 30A,
775 and records pertaining to the administration of the division shall be subject to section 42 of
776 chapter 30 and section 10 of chapter 66. All moneys of the division shall be considered to be
777 public funds for purposes of chapter 12A. Except as otherwise provided in this section, the
778 operations of the division shall be subject to chapter 268A and chapter 268B.

779 (e) The chairperson shall nominate an executive director. Such nomination shall be subject to
780 confirmation by the board. Upon confirmation, such person shall be appointed as executive
781 director. The executive director shall supervise the administrative affairs and general
782 management and operations of the division and also serve as secretary of the division, ex officio.
783 The executive director shall receive a salary commensurate with the duties of the office. The
784 executive director may appoint other officers and employees of the division necessary to the
785 functioning of the division. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter
786 150E shall not apply to the executive director or any other employees of the division. The
787 executive director shall, with the approval of the board:

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

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

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

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

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

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

804 (g) The executive director shall appoint and may remove such agents and subordinate officers as
805 the executive director may deem necessary and may establish such subdivisions within the
806 division as he deems appropriate to fulfill the following duties: (i) to collect, analyze and
807 disseminate health care data to assist in the formulation of health care policy and in the provision
808 and purchase of health care services; (ii) to work with other state agencies including, but not
809 limited to, the department of public health and the department of mental health, the division of
810 medical assistance and the division of insurance to collect and publish data concerning the cost
811 of health insurance in the commonwealth and the health status of individuals; (iii) to hold annual
812 hearings concerning health care provider and payer costs and cost trends, and to provide an

813 analysis of health care spending trends with recommendations for strategies to promote an
814 efficient health delivery system; (iv) to administer the health safety net office and trust fund
815 established under sections 35 and 36; and (v) implement the reform of the health care delivery
816 and payment system in the commonwealth.

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

824 HHS)

825 SECTION 30. Section 2A of chapter 118G of the General Laws, as so appearing, is hereby
826 amended in lines 1 and 2 be striking out the first sentence and inserting in place thereof the
827 following:—

828 The secretary, in consultation with the division, shall establish rates of payment for health care
829 services.

830 SECTION 31. Section 3 of chapter 118G as so appearing is hereby amended by striking out said
831 section in its entirety and inserting in place thereof the following:—

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

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

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

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

838 (b) to acquire, own, hold, dispose of, and encumber personal property and to lease real property
839 in the exercise of its powers and the performance of its duties.

840 (c) to seek and receive any grant funding from the federal government, departments or agencies
841 of the commonwealth, and private foundations.

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

846 (e) to adopt by-laws for the regulation of its affairs and the conduct of its business.

847 (f) to adopt an official seal and alter the same.

848 (g) to maintain an office at such place or places in the commonwealth as it may designate.

849 (h) to sue and be sued in its own name, plead and be impleaded.

850 (i) to establish lines of credit, and establish one or more cash and investment accounts to receive
851 payments for services rendered, appropriations from the commonwealth and for all other
852 business activity granted by this chapter except to the extent otherwise limited by any applicable
853 provision of the Employee Retirement Income Security Act of 1974.

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

856 (k) to acquire, own, hold, dispose of, and encumber personal property and to lease real property
857 in the exercise of its powers and the performance of its duties.

858 (l) to maintain a prudent level of reserve funds to protect the solvency of any trust funds under
859 the operation and control of the division.

860 (m) to enter into interdepartmental agreements with the executive office of health and human
861 services, the division of insurance, the department of public health, and any other state agencies
862 the board deems necessary to implement the provisions of this chapter. The division of insurance
863 shall provide any needed information, support, personnel and other assistance to the division in
864 connection with the implementation of the provisions of this chapter but shall not be subject to
865 the control of the division in connection therewith.

866 SECTION 32. Chapter 118G as so appearing is hereby amended by inserting after section 3 the
867 following 2 sections:—

868 Section 3A. (a) The division shall work with other state agencies including, but not limited to,
869 the department of public health and the department of mental health, the division of medical
870 assistance and the division of insurance to collect and publish data concerning the cost of health
871 insurance in the commonwealth and the health status of individuals; hold annual hearings
872 concerning health care provider and payer costs and cost trends, and to provide an analysis of
873 health care spending trends with recommendations for strategies to promote an efficient health
874 delivery system. The division shall make available actual costs of health care services, as

875 supplied by each provider, to the general public in the manner specified in section 59 of this

876 chapter.

877 (b) The division shall have the power to design and to revise, consistent with this chapter, a basic

878 schedule of health care services that enrollees in any health insurance program implemented by

879 the division shall be eligible to receive. Such covered services shall include those which typically

880 are included in employer-sponsored health benefit plans in the commonwealth. The division may

881 promulgate schedules of covered health care services which differ from the basic schedule and

882 which apply to specific classes of enrollees. The division may promulgate a schedule of premium

883 contributions, co-payments, co-insurance, and deductibles for said programs, including reduced

884 premiums based on a sliding fee, and other fees and revise them from time to time, subject to the

885 approval of the division of insurance; and provided, however, that such schedule shall provide

886 for such enrollees to pay one hundred per cent of such premium contributions if their income

887 substantially exceeds the non-farm poverty guidelines of the United States office of management

888 and budget.

889 (c) The division shall adopt and amend rules and regulations, in accordance with chapter 30A,

890 for the administration of its duties and powers and to effectuate the provisions and purposes of

891 this section. Such regulations shall be adopted, after notice and hearing, only upon consultation

892 with representatives of nonprofit hospital service corporations established under chapter 176A,

893 elected representatives of health systems agencies designated pursuant to Title XV of the federal

894 public health service act, representatives of companies authorized to sell accident and health

895 insurance under chapter 175 and the Massachusetts Hospital Association.

896 Section 3B. The division shall implement the reform of the health care delivery and payment
897 system in the commonwealth in accordance with this chapter. The board shall (i) oversee and
898 regulate the establishment of ACOs;(ii) oversee the development of patient-centered medical
899 homes; (iii) require the adoption of alternative payment methods and health care delivery
900 systems by providers; and (iv) ensure the consistent and effective use by providers of quality
901 measures to promote patient-centered, timely, high-quality and safe care for individuals in the
902 commonwealth.

903 SECTION 33. Section 4 of chapter 118G, as so appearing, is hereby amended by striking out in
904 line 1 the word "commissioner" and inserting in place thereof the following:—executive director

905 SECTION 34. Section 5 of chapter 118G of the General Laws, as so appearing, is hereby
906 repealed.

907 SECTION 35. Section 6 of chapter 118G, as so appearing, is hereby amended by striking the
908 first sentence and inserting in place thereof the following sentence:—

909 The division may promulgate such regulations as necessary to ensure the uniform reporting of
910 revenues, charges, costs, and utilization of health care services and other such data as the
911 division may require of institutional providers and their parent organizations and any other
912 affiliated entities; non-institutional providers including, but not limited to, physician group
913 entities; and ACOs.

914 SECTION 36. Section 6 of chapter 118G of the General Laws, as so appearing, is hereby
915 amended by inserting, in lines 52 and 76, after the words "provider group," the following
916 words:— , accountable care organization, as defined in chapter 118J, physician organization, as
917 defined in section 53H of chapter 111,

918 SECTION 37. Section 6 of chapter 118G of the General Laws, as so appearing, is hereby further
919 amended by inserting, in lines 54 and 77, after the word "hospital", the following words:—

920 , accountable care organization, as defined in chapter 118J, physician organization, as defined in
921 section 53H of chapter 111,

922 SECTION 38. Section 6 ½ of chapter 118G of the General Laws, as so appearing, is hereby
923 amended by inserting, in line 62, after the word "technology" the following words:—and the
924 impact of price transparency on prices

925 SECTION 39. Said section 6½ as so appearing, is hereby further amended by inserting, in line
926 69, after the word "practices" the following words:— the impact of price transparency on prices,

927 SECTION 40. Said section 6½, as so appearing, is hereby further amended by adding at the end
928 thereof the following:—

929 As used in this section, "provider," shall mean any person, corporation partnership,
930 governmental unit, state institution, accountable care organization, physician organization, or any
931 other entity qualified under the laws of the commonwealth to perform or provide health care
932 services.

933 SECTION 41. Said section 6½, as so appearing, is hereby further amended by striking out, in
934 lines 50 and 51, the words "and (x) any witness identified by the attorney general" and inserting
935 in place thereof the following:—

936 (x) accountable care organizations from separate regions of the state; (xi) physician organizations
937 from at least 3 separate regions of the state; and (xii) any witness identified by the attorney
938 general

939 SECTION 42. Chapter 118G of the General Laws, as so appearing, is hereby amended by
940 striking section 6A, as so appearing, and inserting in place thereof the following section:-

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

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

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

962 SECTION 43. Section 7 of chapter 118G of the General Laws, as so appearing, is hereby
963 amended by inserting, in line 1, after the words "executive office", the following:— ", in
964 consultation with the division,"

965 SECTION 44. Section 11 of chapter 118G of the General Laws, as so appearing, is hereby
966 amended by adding the following subsection:—

967 (d) Notwithstanding any general or special law to the contrary, the executive office of health and
968 human services shall require Medicaid, any carrier or other entity which contracts with the office
969 of Medicaid to pay for or arrange for the purchase of health care services, the commonwealth
970 care health insurance program established under chapter 118H, any carrier or other entity which
971 contracts with the commonwealth care health insurance program to pay for or arrange for the
972 purchase of health care services, the group insurance commission established under chapter 32A,
973 and any other state sponsored or state managed plan providing health care benefits to reimburse
974 any licensed hospital facility operating in the commonwealth that has been designated as a
975 critical access hospital pursuant to U.S.C. 1395i-4, in an amount equal to at least 101 percent of
976 allowable costs under each such program, as determined by utilizing the Medicare cost-based
977 reimbursement methodology, for both inpatient and outpatient services provided to eligible
978 patients of such facility.

979 SECTION 45. Section 18B of chapter 118G of the General Laws, as so appearing, is hereby
980 repealed.

981 SECTION 46. Chapter 118G of the General Laws is hereby amended by striking out the section
982 40 in its entirety and inserting in place thereof the following section:-

983 Section 40. (a) Acute hospitals and ambulatory surgical centers shall be assessed a one-time
984 surcharge to be paid to the division for the distressed hospital fund, created under section
985 2DDDD of chapter 29 to be paid by July 1, 2013. The surcharge amount shall equal the product
986 of (i) the surcharge percentage and (ii) the assessment. The division shall calculate the surcharge
987 percentage by dividing the acute hospital's patient service revenue by the total patient service
988 revenues of acute hospitals paying an assessment under this section. The assessment shall equal
989 the product of (i) the total medical spend in calendar year 2011 and (ii) 0.1 per cent. The division
990 shall determine the surcharge percentage for the one-time assessment by December 31, 2012. In
991 the determination of the surcharge percentage, the division shall use the best data available as
992 determined by the division and may consider the effect on projected surcharge payments of any
993 modified or waived enforcement pursuant to subsection (g). The division shall incorporate all
994 adjustments, including, but not limited to, updates or corrections or final settlement amounts, by
995 prospective adjustment rather than by retrospective payments or assessments. The division may
996 waive the assessment for an acute hospital or ambulatory surgical center, it if finds the hospital
997 or ambulatory surgical center is unable to pay the assessment; provided that if an acute hospital
998 or ambulatory surgical is a part of a system, then the system as a whole shall be financially
999 reviewed. The division shall make a determination for waiver based on the following factors: (A)
1000 total revenues, (B) total reserves, (C) total profits, margins or surplus, (D) administrative expense
1001 ratio, and (E) the compensation of executive managers and board members. Provided however,
1002 any hospital system with less than $1,000,000,000 in total net assets and more than 50% of
1003 revenues from public payers shall be exempt from this section.

1004 (b) Surcharge payors shall be assessed a one-time surcharge to be paid to the division for the
1005 distressed hospital fund, created under section 2DDDD of chapter 29 by July 1, 2013. The
1006 surcharge amount shall equal the product of (i) the surcharge percentage and (ii) the assessment.
1007 The division shall calculate the surcharge percentage by dividing the surcharge payor's payments
1008 for acute hospital services by the payment for acute hospital services by all surcharge payors.
1009 The assessment shall equal the product of (i) the total medical spend in calendar year 2011 and
1010 (ii) 0.2 per cent. The division shall determine the surcharge percentage for the one-time
1011 assessment by December 31, 2012. In the determination of the surcharge percentage, the division
1012 shall use the best data available as determined by the division and may consider the effect on
1013 projected surcharge payments of any modified or waived enforcement pursuant to subsection (g).
1014 The division shall incorporate all adjustments, including, but not limited to, updates or
1015 corrections or final settlement amounts, by prospective adjustment rather than by retrospective
1016 payments or assessments. The division may waive the assessment for a payor, if it finds the
1017 payor would not be able to make payment. The division shall take into account the following
1018 factors when determining if a payor is able to pay: (A) total revenues, (B) total premium receipts,
1019 (C) total reserves, (D) total profits, margins or surplus, (E) medical loss ratio and administrative
1020 expense ratio, and (F) the compensation of the executive managers and board members.

1021 (c) The division shall specify by regulation appropriate mechanisms that provide for
1022 determination and payment of an acute hospital, an ambulatory surgical center, or a surcharge
1023 payor's liability, including requirements for data to be submitted by acute hospitals, ambulatory
1024 surgical centers, and surcharge payors.

1025 (d) A hospital's liability to the fund shall in the case of a transfer of ownership be assumed by
1026 the successor in interest to the hospital.

1027 (e) An ambulatory surgical center's liability to the fund shall in the case of a transfer of
1028 ownership be assumed by the successor in interest to the ambulatory surgical center.

1029 (f) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
1030 assumed by the successor in interest to the surcharge payor.

1031 (g) The division shall establish by regulation an appropriate mechanism for enforcing an acute
1032 hospital or surcharge payor's liability to the fund if an acute hospital or surcharge payor does not
1033 make a scheduled payment to the fund; provided, however, that the division may, for the purpose
1034 of administrative simplicity, establish threshold liability amounts below which enforcement may
1035 be modified or waived. Such enforcement mechanism may include assessment of interest on the
1036 unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or
1037 penalties at a rate not to exceed 5 per cent per month. Such enforcement mechanism may also
1038 include notification to the office of Medicaid requiring an offset of payments on the claims of the
1039 acute hospital or surcharge payor, any entity under common ownership or any successor in
1040 interest to the acute hospital or surcharge payor, from the office of Medicaid in the amount of
1041 payment owed to the fund including any interest and penalties, and to transfer the withheld funds
1042 into said fund. If the office of Medicaid offsets claims payments as ordered by the division, the
1043 office of Medicaid shall be considered not to be in breach of contract or any other obligation for
1044 payment of non-contracted services, and an acute hospital or surcharge payor whose payment is
1045 offset under an order of the division shall serve all Title XIX recipients under the contract then in
1046 effect with the executive office of health and human services. In no event shall the division direct
1047 the office of Medicaid to offset claims unless the acute hospital or surcharge payor has
1048 maintained an outstanding liability to the fund for a period longer than 45 days and has received

1049 proper notice that the division intends to initiate enforcement actions under regulations

1050 promulgated by the division.

1051 (h) If an acute hospital or surcharge payor fails to file any data, statistics or schedules or other

1052 information required under this chapter or by any regulation promulgated by the division, the

1053 division shall provide written notice to the acute hospital or surcharge payor. If an acute hospital

1054 or surcharge payor fails to provide required information within 14 days after the receipt of

1055 written notice, or falsifies the same, he shall be subject to a civil penalty of not more than $5,000

1056 for each day on which the violation occurs or continues, which penalty may be assessed in an

1057 action brought on behalf of the commonwealth in any court of competent jurisdiction. The

1058 attorney general shall bring any appropriate action, including injunctive relief, necessary for the

1059 enforcement of this chapter.

1060 (i) Acute hospitals shall not seek an increase in rates to pay for this assessment.

1061 (j) Ambulatory surgical centers shall not seek an increase in rates to pay for this assessment

1062 (k) Surcharge payors shall not seek an increase in premiums to pay for this assessment.

1063 SECTION 47. Chapter 118G as so appearing is hereby further amended by inserting after

1064 section 41 the following 29 sections:—

1065 Section 42. The division shall:

1066 (a) Take actions necessary to ensure the reform of the health care delivery and payment system

1067 by state and private entities in the commonwealth.

1068 (b) Take actions necessary to promote the establishment of ACOs in accordance with the

1069 requirements of chapter 118J and to ensure consistency and efficacy in the establishment and use

1070 of quality measures throughout the commonwealth to promote patient-centered, timely, safe high
1071 quality care for individuals in the commonwealth. The division shall take all necessary actions to
1072 (i) promote ACOs throughout the commonwealth, (ii) support the transition to alternative
1073 payment methods by all payers, and (iii) protect quality, access and patient choice of primary
1074 care provider and accountable care organization for the residents of the commonwealth.

1075 (c) Adopt regulations and issue administrative bulletins and various other forms of official
1076 guidance concerning:

1077 (1) the establishment of ACOs throughout the commonwealth;

1078 (2) the establishment of the standard quality measure set to be used in the evaluation of the
1079 performance of all providers;

1080 (3) requirements and benchmarks for expanding the use of alternative payment methodologies
1081 and reducing the use of fee-for-service methodologies by payers and providers for the purpose of
1082 adopting alternative payment methods across the health care industry by the dates established
1083 under section 43and for the purposes of lowering annual increases in total medical expenditures.

1084 (4) standards for alternative payment methodologies to be utilized in contracts between payers
1085 and ACOs and other providers. Such standards shall include, but not be limited to the
1086 requirement that payment levels to providers under alternative payment methodologies shall be
1087 dependent, in part, on the achievement of quality performance and shall include risk adjustment
1088 for health status. All payers shall develop and employ alternative payment methodologies
1089 consistent with the requirements of this chapter. All contracts between payers and ACOs that
1090 contain a provision for shared savings between the provider and the payer may contain a
1091 mechanism to return a percentage of the savings to the ACO particiapants; and

1092 (5) requirements for disclosure to the division of provider costs, and of payments made by payers
1093 to ACOs and other providers.

1094 (d) Monitor compliance by ACOs, providers, and payers with requirements established pursuant
1095 to this chapter and any implementing regulations promulgated by the division; achievement of
1096 benchmarks toward use of global and alternative payment methods by payers; cost growth trends
1097 in the health care sector of the commonwealth's economy; and cost growth trends under global
1098 and alternative payment methods used by payers in the commonwealth;

1099 (e) Hold hearings to determine appropriate cost growth and other benchmarks for the transition
1100 to the use of alternative payment methods, and payment limits for health care services;

1101 (f) Waive any of its requirements to permit and support innovative demonstrations or pilot
1102 programs; provided that such waivers may only be renewed if material savings or improvements
1103 in the delivery and quality of care can be documented, to the satisfaction of the division.

1104 (g) Allow independent physician associations, physician-hospital organizations, and various
1105 forms of integrated health care organizations and entities to qualify as an ACO if they meet the
1106 criteria as set forth in chapter 118J. The division shall encourage and assist providers with
1107 voluntary adoption of the ACO model of health care service delivery as much as practicable
1108 relative to funding and resources available to the division under this chapter.

1109 (h) Provide by regulation for the certification or licensing of ACOs that meet the requirements of
1110 chapter 118J, and by January 1, 2013 establish by regulation minimum requirements for the
1111 formation of ACOs consistent with the parameters and requirements set forth in chapter 118J

1112 (i) Monitor the formation of ACOs in the commonwealth, and establish any benchmarks deemed
1113 necessary or appropriate to facilitate the transition of health care providers and facilities into
1114 integrated care delivery systems;

1115 (j) Establish safeguards against underutilization of services and protections against and penalties
1116 for inappropriate denials of services or treatment in connection with utilization of any alternative
1117 payment method or transition to a global payment system;

1118 (k) Establish safeguards against and penalties for inappropriate selection of low cost patients and
1119 avoidance of high cost patients by any provider accepting a risk based contract, including but not
1120 limited to requiring that ACOs accept as ACO patients all individuals regardless of payer source
1121 or clinical profile;

1122 (l) Establish parameters to measure and ensure access by disabled and other individuals with
1123 chronic or complex medical conditions to appropriate specialty care;

1124 (m) Establish reporting and disclosure requirements for ACOs and ACO participants in
1125 accordance with the requirements of chapter 118J.

1126 (n) Consistent with quality measurements and standards established by nationally recognized
1127 professional organizations, establish parameters for clinical outcomes beyond the control of the
1128 clinician for which ACOs and ACO participants shall not be financially responsible;

1129 (o) Monitor ACO delivery systems paid under alternative payment methods to ensure that ACOs
1130 possess either internally or through contract arrangements the competencies necessary to operate
1131 as an effective ACO;

1132 (p) Evaluate and provide guidance through regulations relative to consumer protections and any
1133 deficiencies of patient choice of provider that may arise in the transition from a fee-for-service
1134 system. The division shall monitor the movement of patients from and between ACOs, and shall
1135 establish parameters for out-of-ACO arrangements, as well as for patient provider choice and
1136 other consumer protections;

1137 (q) Establish by regulation requirements for ACOs to address consumer grievances.

1138 (r) Review and evaluate provider and payer complaints, and establish by regulation requirements
1139 for ACOs to address provider grievances;

1140 (s) Oversee compliance by ACOs, providers, and payers with requirements established pursuant
1141 to this chapter and any implementing regulations promulgated by the division; barriers to entry
1142 by providers; excess consolidation of ACOs or other integrated services provider groups; and the
1143 trends in patient choice of providers and ACOs;

1144 (t) Ensure that all data collection, analysis, and other submission requirements established under
1145 this chapter are implemented in a manner which promotes administrative simplification, avoids
1146 duplication, and does not impose an undue burden on any entity or individual;

1147 (u) Provide guidance to ACOs and providers seeking to form an ACO, upon request or on its
1148 own initiative, on the potential implications of 42 U.S.C. section 1320a -7b and implementing
1149 regulations, and 42 U.S.C. section 1395nn(a) to (e) and implementing regulations in connection
1150 with such arrangements;

1151 (v) If any ACO, payer or provider fails to comply with any requirement of this chapter or chapter
1152 118J, including failure to meet medical cost growth targets as provided in section 46, to

1153 implement alternative payment methods by the dates established in section 43, to implement
1154 required health information technology by the dates established in chapter 118I, or to submit
1155 required reports or data as required in section 50, the division shall impose a penalties as
1156 provided in this chapter.

1157 (w) Implement a state-wide inter-operable patient health information exchange no later than
1158 January 1, 2017. The health information exchange shall include appropriate privacy and security
1159 safeguards.

1160 (x) Determine and specify in regulation the amount of revenue at risk under shared financial
1161 responsibility arrangements, the standards for quality assessments and shared savings or shared
1162 responsibility thresholds.

1163 This section shall be construed in a manner consistent with any applicable federal laws or
1164 regulations governing ACOs, except as otherwise explicitly provided in this chapter or in the
1165 regulations adopted under it.

1166 Section 43. (a) Commencing no later than January 1, 2014, the group insurance commission, the
1167 commonwealth health insurance connector authority, and any other state funded insurance
1168 program shall, to the maximum extent feasible, implement alternative payment methodologies.

1169 (b) The executive office of health and human services shall seek a federal waiver of statutory
1170 provisions necessary to permit Medicare to participate in such alternative payment
1171 methodologies and use integrated care organizations and ACOs. Upon obtaining federal
1172 approval for Medicare participation, such participation shall be commenced and continued and
1173 the executive office shall seek extensions or additional approvals, as necessary.

1174 (c) Commencing no later than January 1, 2015, private health plans shall, to the maximum extent
1175 feasible, implement alternative payment methodologies. Private health plans may seek a waiver
1176 from the division in order to use a different innovative system, provided, however, that the health
1177 plan seeking the waiver must demonstrate to the satisfaction of the division that any such system
1178 will provide the same level of incentives, risk sharing and cost-savings as the alternative
1179 payment methodologies defined in regulations of the division.

1180 (d) Any provider with 15,000 or more patients must establish that a sufficient portion of such
1181 provider's revenue is derived from contracts with risk-sharing provisions, as defined in
1182 regulations of the division.

1183 (e) Any alternative payment methodology shall include a risk adjustment based on health status.
1184 The division shall create standards for the calculation of risk adjustments and update those
1185 standards on an annual basis. In establishing risk adjustment standards, the division may take
1186 into account functional status, socioeconomic, or cultural factors.

1187 Section 44. Providers and payers who have not implemented compliant alternative payment
1188 methodologies by the date required in section 43, and who have not obtained a waiver under the
1189 provisions of subsection (c) of section 43, shall be subject to a penalty of $1 per member per
1190 month for the period of time during which such provider or payer is not in compliance. The
1191 division shall assess and collect the penalties as provided in this section.

1192 Section 45. (a) By January 1, 2013, the division, in consultation with the office of Medicaid,
1193 shall develop and implement standards of certification for patient-centered medical homes. In
1194 developing these standards, the division shall consider existing standards by the National
1195 Committee for Quality Assurance or other independent accrediting and medical home

1196 organizations. The standards developed by the division shall include, but not limited to, the

1197 following criteria:

1198 (1) Emphasize, enhance, and encourage the use of primary care including prevention and

1199 wellness;

1200 (2) Focus on delivering high-quality, efficient, and effective health care services;

1201 (3) Enhance access to routine care, urgent care, and clinical advice though means such as

1202 implementing shared appointments, open scheduling, and after-hours care.

1203 (4) Encourage patient-centered care, including active participation by the patient and family or

1204 legal guardian in decision making and care plan development;

1205 (5) Provide patients with a consistent, ongoing contact with a provider or team of providers to

1206 ensure continuous and appropriate care for the patient's condition;

1207 (6) Emphasize a multi-disciplinary team-based approach to care;

1208 (7) Ensure care coordination across settings, including referral and transition management;

1209 (8) Ensure that patient-centered medical homes develop and maintain appropriate comprehensive

1210 care plans for their patients with complex or chronic conditions, including an assessment of

1211 health risks and chronic conditions;

1212 (9) Enable and encourage utilization of a range of qualified health care professionals, including

1213 dedicated care coordinators, which may include, but not be limited to nurse practitioners,

1214 physician assistants and social workers, in a manner that enables providers to practice to the

1215 fullest extent of their license;

1216 (10) Ensure the use of health information technology and systematic follow-up, including the use
1217 of patient registries; and

1218 (11) Encourage the use of scientifically based health care, shared decision-making aids that
1219 provide patients with information about treatment options and their associated benefits, risks,
1220 costs, and comparative outcomes, and other clinical decision support tools, including but not
1221 limited to decision aids on long-term care and supports and palliative care.

1222 In developing these standards, the division may consult with national and local organizations
1223 working on medical home models, relevant state agencies, health plans, physicians, nurse
1224 practitioners, behavioral health providers, hospitals, social workers, other health care providers
1225 and consumers.

1226 (b) A primary care provider may be certified as a patient-centered medical home. In order to be
1227 certified as a patient-centered medical home, a primary care provider must meet the standards set
1228 by the division in accordance with this section.

1229 (c) A behavioral health provider may be certified as a patient-centered medical home, provided
1230 that the behavioral health provider addresses the majority of the needs of patients with significant
1231 behavioral health diagnoses requiring the provider's expertise. Such a provider may serve as a
1232 medical home for individuals with significant behavioral health diagnoses. In order to be
1233 certified as a patient-centered medical home, a behavioral health provider must meet the
1234 standards set by the division in accordance with this section.

1235 (d) A specialty care provider may be certified as a patient-centered medical home, provided that
1236 the specialty care provider addresses the majority of the needs of patients with chronic conditions
1237 requiring the specialist's expertise. Such a provider may serve as a medical home for individuals

1238 with chronic conditions requiring the specialist's expertise. In order to be certified as a patient-
1239 centered medical home, a specialty care provider must meet the standards set by the division in
1240 accordance with this section.

1241 (e) Certification as a patient-centered medical home is voluntary. Primary care providers,
1242 behavioral health providers, and specialty care providers shall annually renew their certification
1243 as a patient centered medical home.

1244 (f) A primary care provider or specialty-care provider certified as a patient-centered medical
1245 home shall have the ability to assess and provide or arrange for, and coordinate care with mental
1246 health and substance abuse services, to an extent determined by the division. A behavioral health
1247 provider or specialty care provider certified as a patient-centered medical home shall have the
1248 ability to assess and provide or arrange for, and coordinate care with primary care services, to an
1249 extent determined by the division.

1250 (g) Primary care providers, behavioral health providers, or specialty care providers certified as
1251 patient-centered medical homes shall offer their medical home services to all their patients,
1252 including those with chronic medical or behavioral health conditions, who are interested in
1253 participation.

1254 (h) By July 1, 2013, the division, in consultation with the office of Medicaid, shall establish a
1255 patient-centered medical home training cooperative to provide an opportunity for patient-
1256 centered medical homes to learn the core competencies of the patient-centered medical home
1257 model, and exchange information related to quality improvement and best practices.

1258 (i) Patient-centered medical homes shall participate in the patient-centered medical home
1259 learning training cooperative established under subsection (h).

1260 (j) For continued certification under this section, patient-centered medical homes shall meet
1261 quality standards as under the standard quality measure set, as established by section 68 of
1262 chapter 118G. The division shall collect data from patient-centered medical homes necessary for
1263 monitoring compliance with certifications standards and for evaluating the impact of patient-
1264 centered medical homes on health care quality, cost, and outcomes. The division may contract
1265 with a private entity to perform an evaluation of the effectiveness of patient-centered medical
1266 homes.

1267 (k) In providing after-hours care, a medical home may enter into a cooperative agreement with
1268 another medical home, primary care practice, limited service clinic, as defined by department of
1269 public health, or urgent care center to provide after-hours care for their patients.

1270 (l) The division shall develop a standard payment system for patient-centered medical homes
1271 certified under this section. In developing the standard payment system, the division shall
1272 consider, but not be limited to, per-patient payments, payment levels based on care-complexity,
1273 and payments for care coordination, clinical management, quality performance, and shared
1274 savings. Development of the standard patient-centered medical home payment system shall be
1275 completed by January 1, 2013.

1276 (m) Payers shall make payments to patient-centered medical homes pursuant to the standard
1277 patient-centered medical home payment system established under subsection (l) for network
1278 providers certified as patient-centered medical homes under this section, or an equivalent as
1279 approved by the authority. Medical home payments shall be in addition to any other payments,
1280 such as fee-for-service, global, and bundled payments. Subject to the other provisions of this

1281 legislation, final patient-centered medical home payment amounts shall be determined through

1282 contracts between payors and providers.

1283 (n) The division shall develop and distribute a directory of key, existing referral systems and

1284 resources that can assist patients in obtaining housing, food, transportation, child care, elder

1285 services, long-term care services, peer services, and other community-based services. This

1286 directory shall be made available to patient-centered medical homes in order to connect patients

1287 to services in their community.

1288 (n) Nothing in this section shall preclude the continuation of existing patient-centered medical

1289 home or medical home programs currently operating or under development.

1290 Section 46. (a) The division shall determine and establish the per capita total medical expense,

1291 as defined in section 1, for calendar year 2011, of all providers in the commonwealth for health

1292 care services provided to residents of the commonwealth. The per capita total medical expense

1293 as determined for calendar year 2011 shall be known as the "state base amount."

1294 (b) The following cost growth targets for per capita total medical expense in the commonwealth

1295 are hereby established:

1296 (i) For calendar year 2015, the target for the per capita total medical expense shall be an

1297 amount equal to the state base amount established in accordance with the provisions of

1298 subsection (a) plus an amount equal to the projected percentage increase in per capita potential

1299 gross state product between calendar year 2011 and calendar year 2015 multiplied by the state

1300 base amount. The percentage increase in per capita potential gross state product between

1301 calendar year 2011 and 2015 shall be calculated based on the formula provided in (b) (ii).

1302 (ii) As part of the governor's annual budget submission, the secretary for administration and
1303 finance shall publish the projected percentage increase in per capita potential gross state product
1304 for the calendar year beginning on January 1 following the budget submission. For the purposes
1305 of clause (i), the projected percentage increase in per capita potential gross state product for
1306 calendar years 2012 and 2013 is 3.6%, and the projected percentage increase in per capita
1307 potential gross state product for 2014 and 2015 shall be included in the governor's budget
1308 submissions for fiscal years 2014 and 2015, respectively.

1309 (iii) For calendar years 2016 through 2026, the target for per capita total medical expense
1310 shall be an amount equal to the per capita total medical expense target established for the
1311 previous calendar year plus an amount equal to the projected percentage rate of increase in per
1312 capita potential gross state product for the current calendar year minus 0.5 per cent multiplied by
1313 the target for the previous calendar year. The target amount is therefore the result of the
1314 cumulative growth of the state base amount, based on the formula provided in clause (ii) and this
1315 clause (iii).

1316 (iv) For calendar years 2027 and subsequent years, the target for the per capita total medical
1317 expense shall be an amount equal to the per capita total medical expense target established for
1318 the previous calendar year plus an amount equal to the projected percentage rate increase in per
1319 capita potential gross state product for the current calendar year plus 1 per cent multiplied by the
1320 target for the previous calendar year. The target amount is therefore the result of the cumulative
1321 growth of the state base amount, based on the formula provided in clause (ii), clause (iii), and
1322 this clause (iv).

1323 (c) In addition to calculating the statewide per capita total medical expense target, the division
1324 shall also determine and report annually the per capita risk adjusted total medical expenses for
1325 residents divided into 3 geographic regions, as determined by the division.

1326 (d) The division shall also determine and report annually the per capita risk adjusted total
1327 medical expenses for each payer in the commonwealth for services delivered to residents in
1328 Massachusetts based on each such payer's combined fully-insured business and administrative
1329 services business.

1330 (e) The division shall also determine and report annually the per capita risk adjusted total
1331 medical expense for each type of payer contract including contracts with accountable care
1332 organizations and other contracts as the division deems appropriate.

1333 (f) The division shall also determine and report annually the per capita risk adjusted total medical
1334 expense across all payers in the commonwealth for each of the following types of services for
1335 services delivered to residents of Massachusetts in Massachusetts:—

1336 (i) Primary care related services.

1337 (ii) preventable emergency department and hospital use, specialist services, imaging and
1338 laboratory testing.

1339 (iii) Services provided by high cost providers such as teaching hospitals.

1340 (iv) Behavioral health services.

1341 (v) Services associated with poor quality including but not limited to hospital
1342 readmissions and hospital acquired infections.

1343 (g) For the purposes of this section, the board shall determine the appropriate methodology for
1344 performing risk-adjustment.

1345 Section 47. (a) Within 180 days of the end of each calendar year, the division shall conduct a
1346 review of the growth in state per capita total medical expense and determine whether such
1347 growth is within or exceeds the target growth for such calendar year. Whether or not the target
1348 has been exceeded, the division shall review and analyze the per capita total medical expense
1349 data for the 3 regions as provided in subsection (b) of section 46, the per capita total medical
1350 expense data for payers as provided in subsection (c) of said section, the per capita total medical
1351 expense data for each type of payer contract as provided in subsection (d) of said section and the
1352 per capita total medical expense data for each of the types of services specified in subsection (e)
1353 of said section.

1354 (b) If the per capita total medical expense in the commonwealth, as determined under section 46,
1355 exceeds the target established for such calendar year, the division shall make a determination as
1356 to the cause or causes of the excess increase. If the division determines that the increase is
1357 caused in whole or in part by circumstances beyond the control of providers or payers, the
1358 division may elect to take no action with respect to any provider or payer.

1359 (c) If the per capita total medical expense of all providers in the commonwealth, as determined
1360 under section 46, exceeds the target established for a calendar year, the division may undertake
1361 actions, including but not limited to the following:

1362 (i) The division may make changes to alternative payment methodologies as authorized
1363 in this chapter in order to further enhance the ability of the state to meet spending targets;

1364 (ii) The division may require payers and providers to implement a corrective action plan. The
1365 correction action plan shall be described in a document outlining the steps that the payer or
1366 provider intends to take to reach compliance with spending targets within the next 18 months. If
1367 the division requires a corrective action plan, the plan shall be submitted to the division within 3
1368 months of notice to the payer or provider. The division shall review and approve or disapprove
1369 the plan within 3 months of submission. The division may require the payer or provider to
1370 submit revisions to the corrective action plan. The payer or provider shall commence
1371 implementation of the corrective action plan promptly upon receiving notice of approval of the
1372 plan.

1373 (iii) The division may require payers and providers to reopen contracts that, in the
1374 division's opinion, are contributing to excessive spending growth;

1375 (iv) The division may submit a recommendation for proposed legislation to the joint committee
1376 on health care financing if the division believes that further legislative authority is needed to
1377 achieve the health care quality and spending sustainability objectives of this act.

1378 (d) The division shall annually review the per capita risk adjusted total medical expenses for
1379 payer and payer contracts as determined under section 46, if the division determines that the rate
1380 of increase in per capita risk adjusted total medical expense for a payer or payer contract has
1381 exceeded the cost growth target for the year or is otherwise deemed to be excessive under the
1382 circumstances and that this increase is likely to threaten the ability of the commonwealth to meet
1383 its spending targets in the current year or a future year, the division may take any of the steps
1384 specified in subpart (c). In addition, as appropriate, the division may refer the payer to the
1385 division of insurance or attorney general for further review and appropriate action. A payer or

1386 payer contract may be subject to action or penalty under this section regardless of whether the
1387 statewide per capita total medical expense growth target for that year has been exceeded by other
1388 contracts.

1389 (e) In deciding whether to take action under subparts (c) and (d), the division shall consider
1390 whether such action will enhance the ability of the commonwealth to achieve the health care
1391 quality and spending sustainability objectives of this act.

1392 (f) If the division determines that per capita total medical expense targets or penalties should be
1393 modified, the division shall submit a recommendation for proposed legislation to the joint
1394 committee on health care financing.

1395 Section 48. (a) Every provider shall be subject to market impact review by the division. The
1396 division shall establish by regulation rules for conducting market impact reviews. Such rules
1397 shall define primary service areas and dispersed service areas based on the geographic capacity
1398 of major service categories. The division may conduct a market impact review for provider
1399 when the division determines that market impact review is in the public interest. The division
1400 shall conduct a market impact review for any provider whose market concentration in primary or
1401 dispersed service areas exceeds the antitrust safety zone as set forth in Federal Trade
1402 Commission and Department of Justice Antitrust Division in the final policy statement of
1403 antitrust enforcement policy regarding accountable care organizations participating in the
1404 Medicare shared savings program, 76 FR 67026 et seq. [verify citation]. The division shall
1405 initiate a market impact review by sending such provider a notice of a market impact review
1406 which shall detail the particular factors that it seeks to examine through the review. The division
1407 shall specify by regulation the procedure for conducting the market impact review.

1408 (b) A market impact review may examine factors including, but not limited to: (1) the provider's
1409 size and market share by major service category within its primary service areas and dispersed
1410 service areas, (2) provider price, including its relative prices filed with the division of insurance
1411 pursuant to chapter 176S, (3) provider quality, including patient experience, (4) the availability
1412 and accessibility of services similar to those provided, or proposed to be provided, through the
1413 organization within its primary service areas and dispersed service areas, (5) the provider's
1414 impact on competing options for the delivery of health care services within its primary service
1415 areas and dispersed service areas, (6) the methods used by the organization to attract patient
1416 volume and to recruit or acquire health care professionals or facilities, (7) the role of the
1417 providerin serving at-risk, underserved, and government payer patient populations within its
1418 primary service areas and dispersed service areas, (8) the role of the provider organization in
1419 providing low margin or negative margin services within its primary service areas and dispersed
1420 service areas, (9) the financial solvency of the provider, (10) consumer concerns, including but
1421 not limited to complaints or other allegations that the provider has engaged in any unfair method
1422 of competition or any unfair or deceptive act or practice, and (11) any other factors that the
1423 division determines to be in the public interest.

1424 (c) The department of public health shall submit information to the division regarding any
1425 proposed projects, mergers or acquisitions that will result in a substantial capital expenditure or
1426 substantial change in services under determination of need with respect to a provider.

1427 (d) If after completing a market impact review, the division determines that a substantial capital
1428 expenditure or substantial change in services has resulted or would result in any unfair method of
1429 competition, any unfair or deceptive act or practice, as defined in chapter 93A, or determines that
1430 a proposed project, merger or acquisition will result in a material change under determination of

1431 need that would result in any unfair method of competition, any unfair or deceptive act or
1432 practice, the division shall refer its findings, together with any supporting documents, data or
1433 information to the attorney general for further review and action.

1434 Section 49. (a) The division shall promote transparency of prices and quality in the health care
1435 system to enable payers, providers, employers, and consumers to make informed decisions,
1436 facilitate the coordination of care, and monitor the commonwealth's progress in reducing overall
1437 health care costs. For this purpose, the division shall:—

1438 (i) Establish and monitor goals and benchmarks for reducing health care costs, improving
1439 the quality of the health care system and increasing access to care in the commonwealth;

1440 (ii) Oversee the collection of data from health care providers, payers and consumers on the
1441 cost, quantity, and quality of health care delivered in the commonwealth;

1442 (iii) Specify what data shall be reported and the frequency and manner of reporting;

1443 (iv) Analyze such data to identify health care cost trends and the impact of the transition from
1444 fee-for-service to alternative payment methodologies;

1445 (v) Report to consumers comparative health care price and quality information through the
1446 consumer health education website established under 59 ;

1447 (vi) Commission an annual independent survey of patient and caregiver experience and
1448 satisfaction with the health care system, taking into account care provided by primary care
1449 providers, hospitals, accountable care organizations and other care networks. The survey shall
1450 also assess patients' perceptions on their access to services, including, but not limited to, mental
1451 health and primary care; patients' perceptions of the impact of health insurance premiums and

1452 out-of-pocket expenditures on access to care and affording other necessities; the experience of
1453 vulnerable populations such as the homeless, those with disabilities, women, the elderly and
1454 children; and differences in experience by racial, ethnic and socioeconomic background; and

1455 (vii) Publish reports on the cost, quantity, and quality of health care delivered in the
1456 commonwealth. Such reports shall include, but are not limited to,

1457 A. an initial report that establishes a baseline of the current health care delivery system in
1458 the commonwealth in terms of cost, quality and utilization and market power;

1459 B. an annual report on the implementation of payment reform which shall include, but not
1460 be limited to: the achievement of benchmarks for the reduction of health care costs, improvement
1461 in quality and increased access to care, analyzed by region of the state and resident
1462 demographics; the number, proportion and type of providers affiliating with an accountable care
1463 organization; and performance of accountable care organizations.

1464 C. the proportion of health care expenditures reimbursed under fee-for-service and
1465 alternative payment methodologies; the proportion of patients receiving care inside of an
1466 accountable care organization; the barriers of entry, if any, for an accountable care organization;
1467 the status of patient choice of provider and accountable care organization; and trends in total
1468 medical spending including, but not limited to, cost growth trends for fee-for-service rates and
1469 alternative payment methodologies; cost growth trends for care provided within accountable care
1470 organizations and care provided outside of accountable care organizations; and cost growth
1471 trends by provider sector, including, but not limited to, hospitals, hospital systems, non-acute
1472 providers, prescription drugs, and durable medical equipment; and

1473 D. an annual evaluation of the patient-centered medical home model, as established under
1474 section 45, which shall include, but not be limited to: the number of patients in the
1475 commonwealth in patient-centered medical homes and the number and characteristics of
1476 enrollees with complex or chronic conditions, indentified by income, race, ethnicity and
1477 language; the number and geographic distribution of patient-centered medical home providers;
1478 the performance and quality of patient-centered medical homes; measures of preventive care;
1479 patient-centered medical home payment arrangements, and costs related to implementation and
1480 patient-centered medical home payment fees; the estimated impact of patient-centered medical
1481 homes on health disparities; and estimated savings from implementation of the patient-centered
1482 medical home model on the health care system.

1483 (c) The division shall ensure that all data collection, analysis, and other submission requirements
1484 established under this section are implemented in a manner that promotes administrative
1485 simplification and avoids duplication.

1486 (d) The division shall ensure compliance with all state and federal privacy requirements,
1487 including those imposed by the Health Insurance Portability and Accountability Act of 1996,
1488 P.L. 104-191, the American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§
1489 2.11 et seq., and 45 C.F.R. §§ 160, 162 and 164.

1490 (e) The division shall promulgate regulations necessary for the implementation of the
1491 requirements of this section.

1492 Section 50. (a) To facilitate the sharing of health care data between payers, providers,
1493 employers, and consumers, the division shall:—

1494 (i) Establish procedures for payers to report to members their out-of-pocket costs, including,
1495 but not limited to, requiring payers to provide a toll-free number and website that enables
1496 consumers to request and obtain from a payer in real time the maximum estimated amount the
1497 insured will be responsible to pay for a proposed admission, procedure or service that is a
1498 medically necessary covered benefit, based on the information available to the carrier at the time
1499 the request is made, including any copayment, deductible, coinsurance or other out of pocket
1500 amount, for any health care benefits;

1501 (ii) Establish procedures for the authority to disclose to providers, on a timely basis, the
1502 contracted prices of individual health care services so as to aid in patient referrals and the
1503 management of alternative payment methodologies. Contracted prices shall be listed by provider
1504 and payer;

1505 (iii) Establish procedures for payers to disclose patient-level data including, but not limited to,
1506 health care service utilization, medical expenses, demographics, and where services are being
1507 provided, to all providers in their network, provided that data shall be limited to patients treated
1508 by that provider, so as to aid providers in managing the care of their own patient panel;

1509 (iv) Establish procedures for third-party administrators to disclose to self-insured group
1510 clients the prices and quality of services of in-network providers; and

1511 (v) Establish procedures for health care providers, upon the request of a patient or
1512 prospective patient, to disclose the charges, and if available, the allowed amount, or where it is
1513 not possible to quote a specific amount in advance due to the health care provider's inability to
1514 predict the specific treatment or diagnostic code, the estimated charges or estimated allowed
1515 amount for a proposed admission, procedure or service.

1516 (b) The division shall ensure that all data collection, analysis, and other submission requirements
1517 established under this section are implemented in a manner that promotes administrative
1518 simplification and avoids duplication.

1519 (c) The division shall ensure the timely reporting of information required under this section. The
1520 division may assess penalties against any reporting entity that fails to meet a reporting deadline,
1521 said funds shall be deposited into the wellness and prevention trust fund, as established in section
1522 75 of chapter 10.

1523 Section 51. (a) A payer or any entity acting for a payer under contract, when requiring prior
1524 authorization for a health care service or benefit, shall use and accept only the prior authorization
1525 forms designated for the specific types of services and benefits developed pursuant to subsection
1526 (c).

1527 (b) If a payer or any entity acting for a payer under contract fails to use or accept the required
1528 prior authorization form, or fails to respond within 2 business days after receiving a completed
1529 prior authorization request from a provider, pursuant to the submission of the prior authorization
1530 form developed as described in subsection (c), the prior authorization request shall be deemed to
1531 have been granted.

1532 (c) The division shall develop and implement uniform prior authorization forms for different
1533 health care services and benefits by July 1, 2013. The forms shall cover such health care
1534 services and benefits including but not limited to provider office visits, prescription drug
1535 benefits, imaging and other diagnostic testing, laboratory testing and any other health care
1536 services. The division shall develop forms for different kinds of services as it deems necessary
1537 or appropriate provided that all payers and any entities acting for a payer under contract must use

1538 the uniform form designated by the division for the specific type of service. Six months after the

1539 full set of forms is developed, every provider shall use the appropriate uniform prior

1540 authorization form to request prior authorization for coverage of the health care service or benefit

1541 and every payer or any entity acting for a payer under contract shall accept the form as sufficient

1542 to request prior authorization for the health care service or benefit.

1543 (d) The prior authorization forms developed pursuant to subdivision (c) shall meet the following

1544 criteria:

1545 (1) The forms shall not exceed two pages;

1546 (2) The forms shall be made electronically available;

1547 (3) The payer must be able to electronically accept the completed forms;

1548 (4) The division, in developing the forms, shall seek input from interested stakeholders;

1549 (5) The division shall ensure that the forms are consistent with existing prior authorization forms

1550 established by the federal Centers for Medicare and Medicaid Services; and

1551 (6) The division, in developing the forms, shall consider other national standards pertaining to

1552 electronic prior authorization.

1553 Section 52. The division shall establish standardized processes and procedures applicable to all

1554 health care providers and payers for the determination of a patient's health benefit plan eligibility

1555 at or prior to the time of service by July 1, 2013. As part of such processes and procedures, the

1556 division shall (i) require payers to implement automated approval systems such as decision

1557 support software in place of telephone approvals for specific types of services specified by the

1558 division and (ii) require establishment of an electronic data exchange to allow providers to
1559 determine eligibility at or prior to the point of care.

1560 Section 53. The division shall develop a summary of payments form to be used by all health
1561 care payers in the commonwealth that is provided to health care consumers with respect to
1562 provider claims submitted to a payer and written in an easily readable and understandable format
1563 showing the consumer's responsibility, if any, for payment of any portion of a health care
1564 provider claim by July 1, 2013. The summary of payments form shall include the following
1565 information: (i) provider charges; (ii) contracted rate or allowed amount; (iii) the payment made
1566 by the payer; (iv) the co-pay paid by the consumer; (v) the amount subject to a deductible; and
1567 (vi) any other amount not covered by the payer for which the consumer is responsible, including
1568 co-insurance. The division shall promulgate regulations to implement the requirements of this
1569 section no later than July 1, 2013.

1570 Section 54. The division shall coordinate among state agencies the streamlining and
1571 simplification of state health care data reporting requirements and make recommendations to the
1572 joint committee on health care financing for any necessary legislation to further such
1573 simplification.

1574 Section 55. (a) The division shall require accountable care organizations to provide financial
1575 data on an annual basis before April 1. The division may require information related to its 1)
1576 annual receipts, 2) annual costs, 3) realized capital gains and losses, 4) accumulated surplus, 5)
1577 accumulated reserves, 6) administrative expenses, 7) marketing expenses, 8) charitable expenses,
1578 and 9) any other information deemed necessary by the division.

1579 (b) An accountable care organization who fails to submit such statement before April 1 shall be
1580 assessed a late penalty not to exceed $100 per day. Amounts pursuant to this section shall be
1581 deposited to the Wellness and Prevention Trust Fund established under section 75 of chapter 10
1582 of the General Laws . The division shall make public all of the information collected under this
1583 section. The division shall, from time to time, require accountable care organizations to submit
1584 the underlying data used in their calculations for audit.

1585 The division may adopt rules to carry out this subsection and criteria for the standardized
1586 reporting and uniform allocation methodologies among accountable care organizations. The
1587 division shall, before adopting regulations under this subsection, consult with other agencies of
1588 the commonwealth and the federal government and affected carriers to ensure that the reporting
1589 requirements imposed under the regulations are not duplicative.

1590 Section 56. (a) The division shall calculate a statewide median contracted price for each health
1591 care service provided by hospitals, physician groups, other health care providers licensed under
1592 chapter 112 of the General Laws, and free standing surgical centers. The division shall establish
1593 a uniform methodology to collect all necessary information to calculate such prices. The
1594 statewide median contracted price shall be calculated on an annual basis.

1595 (b) The division shall also calculate a provider-specific average contracted price relative to the
1596 statewide median contracted price for a comparable set of services, based on a weighting formula
1597 to be determined by the division. The division shall also calculate a provider-specific measure of
1598 the total units of service provided, based on a weighting formula to be determined by the
1599 division.

1600 (c) Any hospital, physician group, other health care provider licensed under chapter 112 of the
1601 General Laws, and free standing surgical center shall be assessed a surcharge if their contracted
1602 average price exceeds 120 percent of the comparable statewide median contracted price.

1603 (d) The surcharge amount shall be equal to the product of (i) the surplus amount and (ii) 10 per
1604 cent. The surplus amount shall be equal to the units of comparable services provided multiplied
1605 by the difference between the provider-specific average contracted price and the statewide
1606 median contracted price for the comparable set of services. The division shall exempt units of
1607 service from the surcharge if (1) said service has limited or exclusive availability in the
1608 commonwealth, as determined by the division or (2) the division determines that the quality of
1609 the service is reasonably related to the price.

1610 (e) The assessment shall be paid to the division on a quarterly basis. The funds from the
1611 assessment shall be placed in the distressed hospital trust fund, as established under section
1612 2DDDD of chapter 29.

1613 (f) Providers are prohibited from passing along the costs of this surcharge to consumers.

1614 (f) Failure to report or pay the division in a timely fashion shall result in an interest charge at an
1615 annual rate equal to the weekly average 1-year constant maturity Treasury yield plus 4 per cent,
1616 as published by the Board of Governors of the Federal Reserve System for the calendar week
1617 preceding the date of non-compliance.

1618 (g) The division shall promulgate all necessary regulations to implement this section.

1619 Section 57. (a) Third party administrators of self-funded plans shall implement alternative
1620 payment methods in accordance with this chapter and all other laws. With the input of expert

1621 advice, the division shall evaluate and take measures to address ERISA restrictions and
1622 recommend potential incentives for employers who participate in self-funded plans to participate
1623 in alternative payment methods.

1624 Section 58. (a) The division shall disseminate the data it collects under this section to consumers,
1625 health care providers and payers through: (i) a publicly-accessible consumer health information
1626 website; (ii) reports on performance provided to health care providers; and (iii) any other
1627 analysis and reporting the council deems appropriate.

1628 When collecting data, the division shall, to the extent possible, utilize existing public and private
1629 data sources and agency processes for data collection, analysis and technical assistance. The
1630 division may enter into an interagency service agreement with other state agencies for data
1631 collection analysis and technical assistance.

1632 The division may, subject to chapter 30B, contract with an independent health care organization
1633 for data collection, analysis or technical assistance related to its duties; provided, however, that
1634 the organization has a history of demonstrating the skill and expertise necessary to: (i) collect,
1635 analyze and aggregate data related to quality and cost across the health care system; (ii) identify
1636 quality improvement areas through data analysis; (iii) work with Medicare, MassHealth, and
1637 other insurers' data; (iv) collaborate in the design and implementation of quality improvement
1638 and clinical performance measures; (v) establish and maintain security measures necessary to
1639 maintain confidentiality and preserve the integrity of the data; and (vii) identify and, when
1640 necessary, develop appropriate measures of quality and cost for public reporting of quality and
1641 cost information.

1642 Payers and health care providers shall submit data to the division or an independent health care
1643 organization with which the division has contracted, as required by the division's regulations.
1644 The division, through its rules and regulations, may determine what type of data may reasonably
1645 be required and the format in which it shall be provided.

1646 The division may request that third-party administrators submit data to the division or to an
1647 independent health care organization with which the council has contracted. The division,
1648 through its rules and regulations, may determine the format in which the data shall be provided.
1649 The division shall publicly post a list of third-party administrators that refuse to submit requested
1650 data.

1651 If any payer or health care provider fails to submit required data to the council on a timely basis,
1652 the council shall provide written notice to the payer or health care provider. A payer or health
1653 care provider that fails, without just cause, to provide the required information within 2 weeks
1654 following receipt of the written notice may be required to pay a penalty of $1,000 for each week
1655 of delay; provided, however, that the maximum annual penalty under this section shall be
1656 $50,000.

1657 (b) The division, through its rules and regulations, shall provide access to data it collects
1658 pursuant to this section. Access to data shall include, but not be limited to, disclosing to
1659 providers, on a timely basis, the contracted prices of individual health care services so as to aid
1660 in patient referrals and the management of alternative payment methodologies. Contracted prices
1661 shall be listed by provider and payer. The division shall provide data under conditions that: (i)
1662 protect patient privacy; (ii) prevent collusion or anti-competitive conduct; and (iii) prevent the
1663 release of data that could reasonably be expected to increase the cost of health care. The division

1664 may limit access to data based on its proposed use, the credentials of the requesting party, the
1665 type of data requested or other criteria required to make a determination regarding the
1666 appropriate release of the data. The division shall also limit the requesting party's use and release
1667 of any data to which that party has been given access by the division. The division shall maintain
1668 a database of health care claims submitted pursuant to this section for the purpose of conducting
1669 data analysis and preparing reports to assist in the formulation of health care policy and the
1670 provisions and purchase of health care services.

1671 Data collected by the division under this section shall not be a public record under clause twenty-
1672 sixth of section 7 of chapter 4 or under chapter 66, except as specifically otherwise provided by
1673 the council.

1674 The division shall, through interagency service agreements, allow the use of its data by other
1675 state agencies for review and evaluation of mandated health benefit proposals as required by
1676 section 38C of chapter 3.

1677 (c) The division shall disseminate to health care providers their individualized de-identified data,
1678 including comparisons with other health care providers on the quality, cost and other data to be
1679 published on the consumer health information website.

1680 (d) The division shall coordinate and compile data on quality improvement programs conducted
1681 by state agencies and public and private health care organizations. The division shall consider
1682 programs designed to: (i) improve patient safety in all settings of care; (ii) reduce preventable
1683 hospital readmissions; (iii) prevent the occurrence of and improve the treatment and coordination
1684 of care for chronic diseases; and (iv) reduce variations in care. The division shall make such
1685 information available on the division's consumer health information website. The division may

1686 recommend legislation or regulatory changes as needed to further implement quality
1687 improvement initiatives.

1688 Section 59. (a) The division shall establish and maintain a consumer health information website.
1689 The website shall contain information comparing the quality and cost of health care services and
1690 may also contain general health care information as the division deems appropriate. The website
1691 shall be designed to assist consumers in making informed decisions regarding their medical care
1692 and informed choices among health care providers. Information shall be presented in a format
1693 that is understandable to the average consumer. The division shall take appropriate action to
1694 publicize the availability of its website.

1695 (b) The website shall provide updated information on a regular basis, at least annually, and
1696 additional comparative quality and price information shall be published as determined by the
1697 division. To the extent possible, the website shall include: (i) comparative price information for
1698 the most common referral or prescribed services, as determined by the division, and shall be
1699 listed by facility, provider, provider group practice, accountable care organization, or any other
1700 provider grouping, as determined by the division, provided that such information is categorized
1701 by payor; (ii) comparative quality information, as determined by division, available by facility,
1702 provider, provider group practice, accountable care organization or any other provider grouping,
1703 as determined by the division, for each such service for which comparative price information is
1704 provided; (iii) general information related to each service for which comparative information is
1705 provided; (iv) comparative quality information, as determined by the division, available by
1706 facility, provider, provider group practice or accountable care organization that is not service-
1707 specific, including information related to patient safety and satisfaction; (v) data concerning
1708 healthcare-associated infections and serious reportable events reported under section 51H of

1709 chapter 111; (vi) definitions of common health insurance and medical terms including, but not
1710 limited to those determined under sections 2715(g)(2) and (3) of the Public Service Act, so that
1711 consumers may compare health coverage and understand the terms of their coverage,; (vii) a list
1712 of health care provider types, including but not limited to primary care physicians, nurse
1713 practitioners and physician assistants, and what types of services they are authorized to perform
1714 in the commonwealth under state and federal scope of practice laws; (viii) factors consumers
1715 should consider when choosing an insurance product or provider group, including, but not
1716 limited to provider network, premium, cost-sharing, covered services, and tiering; ix) decision
1717 aids for patients to facilitate conversations with their health care providers on key health
1718 decisions; and (x) descriptions of standard quality measures, as determined by the division.

1719 (c) The division shall develop and adopt, on an annual basis, a reporting plan specifying the
1720 quality and cost measures to be included on the consumer health information website and the
1721 security measures used to maintain confidentiality and preserve the integrity of the data. In
1722 developing the reporting plan, the division, to the extent possible, shall collaborate with other
1723 organizations or state or federal agencies that develop, collect and publicly report health care
1724 quality and cost measures and the division shall give priority to those measures that are already
1725 available in the public domain. As part of the reporting plan, the division shall determine for
1726 each service the comparative information to be included on the consumer health information
1727 website.

1728 Section 60. There shall be a task force consisting of 13 members with expertise in behavioral
1729 health treatment, service delivery, integration of behavioral health with primary care, and
1730 behavioral health reimbursement systems. Members shall include one representative from each
1731 of the following organizations representing mental health professionals and clinical, hospital and

1732 consumer advocacy groups: Massachusetts Psychiatric Society, Massachusetts Psychological
1733 Association, National Association of Social Workers- Massachusetts Chapter, Massachusetts
1734 Mental Health Counselors Association, Nurses United for Responsible Services, Massachusetts
1735 Association for Registered Nurses, Massachusetts Association of Behavioral Health Systems,
1736 Association for Behavioral Healthcare, Mental Health Legal Advisors Committee, National
1737 Alliance for the Mentally Ill, Children's Mental Health Campaign, Home Care Alliance of
1738 Massachusetts and one member chosen by the governor . The task force shall report to the
1739 division its findings and recommendations relative to (a) the most effective and appropriate
1740 approach to including behavioral health services in the array of services provided by ACOs,
1741 including transition planning for providers and maintaining continuity of care; (b) how current
1742 prevailing reimbursement methods and covered behavioral health benefits may need to be
1743 modified to achieve more cost effective, integrated and high quality behavioral health outcomes
1744 including attention to interoperative electronic health records; (c) the extent to which and how
1745 payment for behavioral health services should be included under alternative payment
1746 methodologies established or regulated under this act including how mental health parity and
1747 patient choice of providers and services could be achieved and the design and use of medical
1748 necessity criteria and protocols; (d) how best to educate all providers to recognize behavioral
1749 health conditions and make appropriate decisions regarding referral to behavioral health services;
1750 and (e) the unique privacy factors required for the integration of behavioral health information
1751 into interoperative electronic health records. The first meeting shall be convened within 60 days
1752 after passage of this act. The task force shall submit its report findings and recommendations to
1753 the division no later than February 1, 2013.

1754 Section 61. (a) There shall be in the division a health care workforce center to improve access to
1755 health care services. The center and the commissioner of labor and workforce development,
1756 shall: (i) coordinate the department's health care workforce activities with other state agencies
1757 and public and private entities involved in health care workforce training, recruitment and
1758 retention; (ii) monitor trends in access to primary care providers, nurse practitioners practicing as
1759 primary care providers, and other physician and nursing providers, through activities including:
1760 (1) review of existing data and collection of new data as needed to assess the capacity of the
1761 health care workforce to serve patients, including patient access and regional disparities in access
1762 to physicians or nurses and to examine physician and nursing satisfaction; (2) review existing
1763 laws, regulations, policies, contracting or reimbursement practices, and other factors that
1764 influence recruitment and retention of physicians and nurses; (3) making projections on the
1765 ability of the workforce to meet the needs of patients over time; (4) identifying strategies
1766 currently being employed to address workforce needs, shortages, recruitment and retention; (5)
1767 studying the capacity of public and private medical and nursing schools in the commonwealth to
1768 expand the supply of primary care physicians and nurse practitioners practicing as primary care
1769 providers; (iii) establish criteria to identify underserved areas in the commonwealth for
1770 administering the loan repayment program established under section 63 and for determining
1771 statewide target areas for health care provider placement based on the level of access; and (iv)
1772 address health care workforce shortages through the following activities, including: (1)
1773 coordinating state and federal loan repayment and incentive programs for health care providers;
1774 (2) providing assistance and support to communities, physician groups, community health
1775 centers and community hospitals in developing cost-effective and comprehensive recruitment
1776 initiatives; (3) maximizing all sources of public and private funds for recruitment initiatives; (4)

1777 designing pilot programs and make regulatory and legislative proposals to address workforce
1778 needs, shortages, recruitment and retention; (5) making short-term and long-term programmatic
1779 and policy recommendations to improve workforce performance, address identified workforce
1780 shortages and recruit and retain physicians and nurses; and (6) administering the health care
1781 workforce trust fund as established under section 2CCCC of chapter 29.

1782 (b) The center shall maintain ongoing communication and coordination the health disparities
1783 council, established by section 16O of chapter 6A.

1784 (c) The center shall annually submit a report, not later than March 1, to the governor, the health
1785 disparities council established by section 16O of chapter 6A; and the general court, by filing the
1786 report with the clerk of the house of representatives, the clerk of the senate, the joint committee
1787 on labor and workforce development, the joint committee on health care financing, and the joint
1788 committee on public health. The report shall include: (i) data on patient access and regional
1789 disparities in access to physicians, by specialty and sub-specialty, and nurses; (ii) data on factors
1790 influencing recruitment and retention of physicians and nurses; (iii) short and long-term
1791 projections of physician and nurse supply and demand; (iv) strategies being employed by the
1792 council or other entities to address workforce needs, shortages, recruitment and retention; (v)
1793 recommendations for designing, implementing and improving programs or policies to address
1794 workforce needs, shortages, recruitment and retention; and (vi) proposals for statutory or
1795 regulatory changes to address workforce needs, shortages, recruitment and retention.

1796 Section 62. (a) There shall be a health care workforce loan repayment program, administered by
1797 the health care workforce center established by section 61. The program shall provide repayment
1798 assistance for medical school loans to participants who: (i) are graduates of medical or nursing

1799 schools; (ii) specialize in family health or medicine, internal medicine, pediatrics, psychiatry, or
1800 obstetrics/gynecology; (iii) demonstrate competency in health information technology at least
1801 equivalent to federal meaningful use standards as set forth in 45 C.F.R. Part 170, including use of
1802 electronic medical records, computerized physician order entry and e-prescribing; and (iv) meet
1803 other eligibility criteria, including service requirements, established by the board. Each recipient
1804 shall be required to enter into a contract with the commonwealth which shall obligate the
1805 recipient to perform a term of service of no less than 2 years in medically underserved areas as
1806 determined by the center.

1807 (b) The center shall promulgate regulations for the administration and enforcement of this
1808 section which shall include penalties and repayment procedures if a participant fails to comply
1809 with the service contract.

1810 The center shall establish criteria to identify medically underserved areas within the
1811 commonwealth. These criteria shall consist of quantifiable measures, which may include the
1812 availability of primary care medical services within reasonable traveling distance, poverty levels,
1813 and disparities in health care access or health outcomes.

1814 Section 63. (a) As used in this section, "primary care provider", shall mean a health care
1815 professional qualified to provide general medical care for common health care problems who (1)
1816 supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2)
1817 initiates referrals for specialist care; and (3) maintains continuity of care within the scope of
1818 practice.

1819 (b) Pursuant to regulations to be promulgated by the division, there shall be established a
1820 primary care residency grant program for the purpose of financing the training of primary care

1821 providers at teaching community health centers. Eligible applicants shall include teaching
1822 community health centers accredited through affiliations with a Commonwealth funded medical
1823 school or licensed as part of a teaching hospital with a residency program in primary care or
1824 family medicine and teaching health centers that are the independently accredited sponsoring
1825 organization for the residency program and whose residents are employed by the health center.

1826 To receive funding, an applicant shall a) include a review of recent graduates of the community
1827 health center's residency program, including information regarding what type of practice said
1828 graduates are involved in two years following graduation from the residency program; and b)
1829 achieve a threshold of at least 50 percent for the percentage of graduates practicing primary care
1830 within two years after graduation. Graduates practicing a) more than 50 percent inpatient care or
1831 b) more than 50 percent specialty care as listed in the American Medical Association Masterfile
1832 shall not qualify as graduates practicing primary care.

1833 Awardees of the primary care residency grant program shall maintain their teaching accreditation
1834 as either an independent teaching community health center or as a teaching community health
1835 center accredited through affiliation with a Commonwealth funded medical school or licensed as
1836 part of a teaching hospital.

1837 The division shall determine via regulation grant amounts per full-time resident. Funds for such
1838 grants shall come from the health care workforce trust fund established under section 2CCCC of
1839 chapter 29.

1840 Section 64. Pursuant to regulations to be promulgated by the division, there shall be established a
1841 primary care workforce development and loan forgiveness grant program at community health
1842 centers, for the purpose of enhancing recruitment and retention of primary care physicians and

1843 other clinicians at community health centers throughout the commonwealth. Such grant program
1844 shall be administered by the Massachusetts League of Community Health Centers in consultation
1845 with the director of the health care workforce center and relevant member agencies. Funds shall
1846 be matched by other public and private funds. The League shall work with said director and said
1847 agencies to maximize all sources of public and private funds.

1848 Section 65. (a) There is hereby established within the division an office of patient protection. The
1849 office shall:—

1850 (1) have the authority to administer and enforce the standards and procedures established by
1851 sections 13, 14, 15 and 16 of chapter 176O. The division shall promulgate such regulations to
1852 enforce this section. Such regulations shall protect the confidentiality of any information about a
1853 carrier or utilization review organization, as defined in said chapter 176O, which, in the opinion
1854 of the office, and in consultation with the division of insurance, is proprietary in nature. The
1855 regulations authorized by this section shall be consistent with, and not duplicate or overlap with,
1856 regulations promulgated by the bureau of managed care established in the division of insurance
1857 pursuant to said chapter 176O;

1858 (2) make managed care information collected by the office readily accessible to consumers on
1859 the division of health care cost and quality website. The information shall, at a minimum, include
1860 (i) the health plan report card developed pursuant to section 24 of chapter 118G, (ii) a chart,
1861 prepared by the office, comparing the information obtained on premium revenue expended for
1862 health care services as provided pursuant to subsection (3) of paragraph (b) of section 7 of
1863 chapter 176O, for the most recent year for which information is available, and (iii) data collected
1864 pursuant to paragraph (c);

1865 (3) assist consumers with questions or concerns relating to managed care, including but not
1866 limited to exercising the grievance and appeals rights established by sections 13 and 14 of said
1867 chapter 176O;

1868 (4) monitor quality-related health insurance plan information relating to managed care practices;

1869 (5) regulate the establishment and functions of review panels established by section 14 of chapter
1870 176O;

1871 (6) periodically advise the division, the commissioner of insurance, the managed care oversight
1872 board established by section 16D of chapter 6A, the joint committee on health care financing and
1873 the joint committee on financial services on actions, including legislation, which may improve
1874 the quality of managed care health insurance plans; and

1875 (7) administer and grant enrollment waivers under paragraph (4) of subsection (a) of section 4 of
1876 chapter 176J; provided, however, that the office of patient protection may grant a waiver to an
1877 eligible individual who certifies, under penalty of perjury, that such individual did not
1878 intentionally forego enrollment into coverage for which the individual is eligible and that is at
1879 least actuarially equivalent to minimum creditable coverage; provided further, that the office
1880 shall establish by regulation standards and procedures for enrollment waivers.

1881 (8) establish by regulation procedures and rules relating to appeals by consumers aggrieved by
1882 restrictions on patient choice, denials of services or quality of care resulting from any final action
1883 of an accountable care organizations, and to conduct hearings and issue rulings on appeals
1884 brought by ACO consumers that are not otherwise properly heard through the consumer's payer
1885 or provider.

1886 (b) The commissioner of insurance shall establish an external review system for the review of
1887 grievances submitted by or on behalf of insureds of carriers pursuant to section 14 of chapter
1888 176O. The division shall establish an external review process for the review of grievances
1889 submitted by or on behalf of ACO patients and shall specify the maximum amount of time for
1890 the completion of a determination and review after a grievance is submitted. The division shall
1891 establish expedited review procedures applicable to emergency situations, as defined by
1892 regulation promulgated by the division.

1893 (c) Each entity that compiles the health plan employer data and information set, so-called, for
1894 the National Committee on Quality Assurance, or collects other information deemed by the
1895 entity as similar or equivalent thereto, shall, upon submitting said data and information sent to
1896 the division of health care cost and quality pursuant to section 24 of chapter 118G, concurrently
1897 submit to the office of patient protection a copy thereof excluding, at the entity's option,
1898 proprietary financial data.

1899 Section 66. (a) All expenses incurred in carrying out this chapter shall be payable solely from
1900 funds provided under the authority of this chapter and no liability or obligations shall be incurred
1901 by the division hereunder beyond the extent to which monies shall have been provided under
1902 this chapter.

1903 (b) The division shall be liable on all claims made as a result of the activities, whether ministerial
1904 or discretionary, of any member, officer, or employee of the division acting as such, except for
1905 willful dishonesty or intentional violation of the law, in the same manner and to the same extent
1906 as a private person under like circumstances; provided, however, that the division shall not be

1907 liable to levy or execution on any real or personal property to satisfy judgment, for interest prior
1908 to judgment, for punitive damages or for any amount in excess of $100,000.

1909 (c) No person shall be liable to the commonwealth, to the division or to any other person as a
1910 result of his activities, whether ministerial or discretionary, as a member, officer or employee of
1911 the division except for willful dishonesty or intentional violation of the law; provided, however,
1912 that such person shall provide reasonable cooperation to the division in the defense of any claim.
1913 Failure of such person to provide reasonable cooperation shall cause him to be jointly liable with
1914 the division, to the extent that such failure prejudiced the defense of the action.

1915 (d) The division may indemnify or reimburse any person, or his personal representative, for
1916 losses or expenses, including legal fees and costs, arising from any claim, action, proceeding,
1917 award, compromise, settlement or judgment resulting from such person's activities, whether
1918 ministerial or discretionary, as a member, officer or employee of the division; provided that the
1919 defense of settlement thereof shall have been made by counsel approved by the division. The
1920 division may procure insurance for itself and for its members, officers and employees against
1921 liabilities, losses and expenses which may be incurred by virtue of this section or otherwise.

1922 (e) No civil action hereunder shall be brought more than 3 years after the date upon which the
1923 cause thereof accrued.

1924 (f) Upon dissolution, liquidation or other termination of the division, all rights and properties of
1925 the division shall pass to and be vested in the commonwealth, subject to the rights of lien holders
1926 and other creditors. In addition, any net earnings of the division, beyond that necessary for
1927 retirement of any indebtedness or to implement the public purpose or purposes or program of the
1928 commonwealth, shall not inure to the benefit of any person other than the commonwealth.

1929 Section 67. The division shall keep an accurate account of all its activities and of all its receipts
1930 and expenditures and shall annually make a report thereof as of the end of its fiscal year to its
1931 board, to the governor, to the general court, and to the state auditor, such reports to be in a form
1932 prescribed by the board, with the written approval of the auditor. The auditor may investigate the
1933 affairs of the division, may severally examine the properties and records of the division, and may
1934 prescribe methods of accounting and the rendering of periodic reports in relation to projects
1935 undertaken by the division. The division shall be subject to biennial audit by the state auditor.

1936 Section 68. The division shall develop the uniform reporting of a standard set of health care
1937 quality measures for each health care provider facility, medical group, or provider group in the
1938 commonwealth hereinafter referred to as the "Standard Quality Measure Set."

1939 The division shall convene a statewide advisory committee which shall recommend to the
1940 division a Standard Quality Measure Set. The statewide advisory committee shall consist of the
1941 executive director of the division or designee, who shall serve as the chair; the executive director
1942 of the group insurance commission or designee, the Medicaid director designee; and 6
1943 representatives of organizations to be appointed by the governor including at least 1
1944 representative from an acute care hospital or hospital association, 1 representative from a
1945 provider group or medical association or provider association, 1 representative from a medical
1946 group, 1 representative from a private health plan or health plan association, 1 representative
1947 from an employer association and 1 representative from a health care consumer group.

1948 In developing its recommendation of the Standard Quality Measure Set, the advisory committee
1949 shall, after consulting with state and national organizations that monitor and develop quality and
1950 safety measures, select from existing quality measures and shall not select quality measures that

1951 are still in development or develop its own quality measures. The committee shall annually
1952 recommend to the division any updates to the Standard Quality Measure Set by November 1. For
1953 its recommendation beginning in 2012, the committee may solicit for consideration and
1954 recommend other nationally recognized quality measures not yet developed or in use as of
1955 November 1, 2010, including recommendations from medical or provider specialty groups as to
1956 appropriate quality measures for that group's specialty. At a minimum, the Standard Quality
1957 Measure Set shall consist of the following quality measures: (i) the Centers for Medicare and
1958 Medicaid Services hospital process measures for acute myocardial infarction, congestive heart
1959 failure, pneumonia and surgical infection prevention; (ii) the Hospital Consumer Assessment of
1960 Healthcare Providers and Systems survey; (iii) the Healthcare Effectiveness Data and
1961 Information Set reported as individual measures and as a weighted aggregate of the individual
1962 measures by medical or provider group; and (iv) the Ambulatory Care Experiences Survey.

1963 The division shall require all payers to limit their collection and utilization of health care quality
1964 measures from providers to the standard quality measure set, as developed by the division under
1965 this section.

1966 Section 69. (a) Acute hospitals, as defined in section 34, ambulatory surgical centers, as defined
1967 in 34, accountable care organizations, as defined in section 1, and physician organizations, as
1968 defined in section 53H of chapter 111, shall pay for the estimated expenses of the division and
1969 health safety net office. The amount to be paid for such expenses shall be equal to the net
1970 amount, as defined in subsection (g). Acute hospitals, ambulatory surgical centers, accountable
1971 care organizations and physician organizations shall assess an administrative surcharge on all
1972 payments subject to administrative surcharge as defined in subsection (g). The administrative
1973 surcharge shall be distinct from any other amount paid by an administrative surcharge payer, as

1974 defined in subsection (g), for the services of an acute hospital, ambulatory surgical center,
1975 accountable care organization or physician organization and shall be in addition to the surcharge
1976 imposed under section 38. The administrative surcharge amount shall equal the product of (i) the
1977 administrative surcharge percentage and (ii) amounts paid for these services by an administrative
1978 surcharge payer. The division shall calculate the administrative surcharge percentage by dividing
1979 the net amount, as defined in this section, by the projected annual aggregate payments subject to
1980 the administrative surcharge, excluding projected annual aggregate payments based on payments
1981 made by managed care organizations. The division shall subsequently adjust the administrative
1982 surcharge percentage for any variation in the net amount. The division shall determine the
1983 administrative surcharge percentage before the start of each fiscal year and may recalculate the
1984 surcharge percentage before April 1 of each fiscal year if the office projects that the initial
1985 administrative surcharge percentage established the previous October will produce less or more
1986 than the net amount in administrative surcharge payments, excluding payments made by
1987 managed care organizations, as defined in section 34. Before each succeeding October 1, the
1988 division shall recalculate the administrative surcharge percentage incorporating any adjustments
1989 from earlier years. In each calculation or recalculation of the administrative surcharge
1990 percentage, the division shall use the best data available as determined by the division and may
1991 consider the effect on projected administrative surcharge payments of any modified or waived
1992 enforcement pursuant to subsection (e). The division shall incorporate all adjustments, including,
1993 but not limited to, updates or corrections or final settlement amounts, by prospective adjustment
1994 rather than by retrospective payments or assessments. In the event of late payment by an
1995 administrative surcharge payer, the treasurer shall advance the amount of due and unpaid funds
1996 to the division prior to the receipt of such monies in anticipation of such revenues up to the

1997 amount authorized in the then current budget attributable to the administrative surcharge, and the
1998 division shall reimburse the treasurer for such advances upon receipt of such revenues. The
1999 provisions of this paragraph shall not apply to any state institution or to any acute hospital which
2000 is operated by a city or town.

2001 (b) Each acute hospital, ambulatory surgical center, accountable care organization and physician
2002 organization shall bill an administrative surcharge payer an amount equal to the administrative
2003 surcharge described in this section as a separate and identifiable amount distinct from any
2004 amount paid by an administrative surcharge payer for acute hospital, ambulatory surgical center,
2005 ACO or physician organization services, and as a separate and identifiable amount distinct from
2006 any surcharge paid under section 38. Each administrative surcharge payer shall pay the
2007 administrative surcharge amount to the division. Each administrative surcharge payer shall make
2008 a preliminary payment to the division on October first of each year in an amount equal to one-
2009 half of the previous year's administrative surcharge amount. Thereafter, each administrative
2010 surcharge payer shall pay, within 30 days of the date of notice from the division, the balance of
2011 the total administrative surcharge amount for the current year Upon the written request of an
2012 administrative surcharge payer, the division may implement another billing or collection method
2013 for the surcharge payer; provided, however, that the division has received all information that it
2014 requests which is necessary to implement such billing or collection method; and provided
2015 further, that the division shall specify by regulation the criteria for reviewing and approving such
2016 requests and the elements of such alternative method or methods.

2017 (c) The division shall specify by regulation appropriate mechanisms that provide for
2018 determination and payment of an administrative surcharge payer's liability, including

2019 requirements for data to be submitted by administrative surcharge payers, ambulatory surgical

2020 center, acute hospitals, ACOs and physician organizations.

2021 (d) An administrative surcharge payer's liability to the commonwealth shall in the case of a

2022 transfer of ownership be assumed by the successor in interest to the administrative surcharge

2023 payer.

2024 (e) The division shall establish by regulation an appropriate mechanism for enforcing an

2025 administrative surcharge payer's liability to the division if an administrative surcharge payer

2026 does not make a scheduled payment to the fund; provided, however, that the division may, for

2027 the purpose of administrative simplicity, establish threshold liability amounts below which

2028 enforcement may be modified or waived. Such enforcement mechanism may include assessment

2029 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent

2030 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement

2031 mechanism may also include notification to the office of Medicaid requiring an offset of

2032 payments on the claims of the administrative surcharge payer, any entity under common

2033 ownership or any successor in interest to the administrative surcharge payer, from the office of

2034 Medicaid in the amount of payment owed to the commonwealth including any interest and

2035 penalties, and to transfer the withheld funds to the commonwealth. If the office of Medicaid

2036 offsets claims payments as ordered by the division, the office of Medicaid shall be considered

2037 not to be in breach of contract or any other obligation for payment of non-contracted services,

2038 and an administrative surcharge payer whose payment is offset under an order of the division

2039 shall serve all Title XIX recipients under the contract then in effect with the executive office of

2040 health and human services. In no event shall the division direct the office of Medicaid to offset

2041 claims unless the administrative surcharge payer has maintained an outstanding liability to the

2042 fund for a period longer than 45 days and has received proper notice that the division intends to
2043 initiate enforcement actions under regulations promulgated by the division.

2044 (f) If an administrative surcharge payer, ambulatory surgical center, acute hospital, accountable
2045 care organization or physician organization fails to file any data, statistics or schedules or other
2046 information required under subsection (c) or by any regulation promulgated by the division in
2047 connection with the administrative surcharge, the division shall provide written notice to the
2048 administrative surcharge payer, ambulatory surgical center, acute hospital, accountable care
2049 organization or physician organization, as the case may be. If an administrative surcharge payer,
2050 ambulatory surgical center, acute hospital, accountable care organization or physician
2051 organization fails to provide required information within 14 days after the receipt of written
2052 notice, or falsifies the same, he shall be subject to a civil penalty of not more than $5,000 for
2053 each day on which the violation occurs or continues, which penalty may be assessed in an action
2054 brought on behalf of the commonwealth in any court of competent jurisdiction. The attorney
2055 general shall bring any appropriate action, including injunctive relief, necessary for the
2056 enforcement of this chapter.

2057 (g) As used in this section, the following words the following words shall, unless the context
2058 clearly requires otherwise, have the following meanings:-

2059 “Administrative surcharge payer”, an individual or entity that pays for or arranges for the
2060 purchase of health care services provided by acute hospitals, ambulatory surgical centers,
2061 accountable care organizations or physician organizations, as defined in this chapter; provided,
2062 however, that the term “administrative surcharge payer” shall include a managed care
2063 organization; and provided further, that “administrative surcharge payer” shall not include Title

2064 XVIII and Title XIX programs and their beneficiaries or recipients, other governmental
2065 programs of public assistance and their beneficiaries or recipients and the workers' compensation
2066 program established under chapter 152.

2067 "Net amount" shall mean the amount established for the estimated annual expenses of the
2068 division of health care cost and quality, established by section 2 and the health safety net office,
2069 established by section 35. This amount shall be equal to the amount appropriated by the general
2070 court for the expenses of the division of health care cost and quality and the health safety net
2071 office minus amounts collected from (1) filing fees, (2) fees and charges generated by the
2072 division's publication or dissemination of reports and information, (3) federal matching revenues
2073 received for these expenses or received retroactively for expenses of predecessor agencies.
2074 Estimated and actual expenses of the division and the office shall include an amount equal to the
2075 cost of fringe benefits, as established by the division of administration pursuant to section 6B of
2076 chapter 29

2077 "Payments subject to administrative surcharge", shall mean all amounts paid, directly or
2078 indirectly, by administrative surcharge payers to acute hospitals, ambulatory surgical centers,
2079 accountable care organizations and physician organizations for health services; provided,
2080 however, that "payments subject to administrative surcharge" shall not include: (i) payments,
2081 settlements and judgments arising out of third party liability claims for bodily injury which are
2082 paid under the terms of property or casualty insurance policies; (ii) payments made on behalf of
2083 Medicaid recipients, Medicare beneficiaries or persons enrolled in policies issued under chapter
2084 176K or similar policies issued on a group basis; provided further, that "payments subject to
2085 administrative surcharge" shall include payments made by a managed care organization on
2086 behalf of: (i) Medicaid recipients under age 65; and (ii) enrollees in the commonwealth care

2087 health insurance program; and provided further, that "payments subject to administrative

2088 surcharge" may exclude amounts established under regulations promulgated by the division for

2089 which the costs and efficiency of billing an administrative surcharge payer or enforcing

2090 collection of the surcharge from an administrative surcharge payer would not be cost effective.

2091 Section 70. Every health care provider, as defined in section 1 of chapter 118G, shall track and

2092 report quality information at least annually under regulations promulgated by the department.

2093 The division shall disclose quality information collected under this section and section 51H of

2094 chapter 111 to providers defined by said division.

2095 SECTION 48. Chapter 118H of the General Laws is hereby amended by inserting after section 6

2096 the following section:-

2097 Section 7. The commonwealth care health insurance program shall attribute every member to a

2098 primary care provider.

2099 SECTION 49. Section 25B of chapter 111, as so appearing, is hereby amended, in line 24, by

2100 striking out the figure "$7,500,000" and inserting in place thereof the following figure:-

2101 "$10,000,000".

2102 SECTION 50. Section 25B of chapter 111, as so appearing, is hereby amended, in line 35, by

2103 inserting the word "has" the following word:- "been".

2104 SECTION 51. Section 25B of chapter 111, as so appearing, is hereby amended, in line 43, by

2105 striking out the figure "$25,000,000" and inserting in place thereof the following figure:-

2106 "$10,000,000"

2107 SECTION 52. Section 25B of chapter 111, as so appearing, is hereby amended, in line 47 and
2108 48, by striking out the phrase ", institution for the care of unwed mothers".

2109 SECTION 53. Section 25B of chapter 111, as so appearing, is hereby amended, in line 49, by
2110 striking out the phrase ", which is an infirmary maintained in a town".

2111 SECTION 54. Section 25B of chapter 111, as so appearing, is hereby amended, in line 54, by
2112 striking out the phrase "mentally ill or retarded" and inserting in place thereof the following:-
2113 "developmentally disabled or mentally ill".

2114 SECTION 55. Section 25B of chapter 111, as so appearing, is hereby amended, in line 85, by
2115 inserting after the word "basis" the following phrase:- "whether provided in a free standing
2116 ambulatory surgical center licensed as a clinic pursuant to section 51 or by a hospital.

2117 SECTION 56. Section 25B of chapter 111 is hereby amended by striking out the definition
2118 "Innovative service" and inserting in place thereof the following definition:-

2119 "Innovative service", a service or procedure, which for reasons of quality, access, or cost is
2120 determined to be innovative by the department.

2121 SECTION 57. Section 25B of chapter 111 is hereby amended by striking out the definition
2122 "New technology" and inserting in place thereof the following definition:-

2123 "New technology", equipment such as magnetic resonance imagers, and linear accelerators or
2124 interventional radiology units as defined by the department, or a service, as defined by the
2125 department, which for reasons of quality, access or cost is determined to be new technology by
2126 the department.

2127 SECTION 58. Section 25B of chapter 111, as appearing, is hereby amended, in lines 120-121,
2128 the words "A new technology or innovate" and inserting in place thereof the following words:-
2129 "a new technology or innovative"

2130 SECTION 59. Section 25B of chapter 111, as appearing, is hereby amended, in line 122, after
2131 parenthesis (b) the following new words:- "for any acute hospital, any increase in bed capacity of
2132 more than 4 beds, (c)"

2133 SECTION 60. Section 25B of chapter 111, as so appearing, is amended by striking out, in lines
2134 149-154, the last sentence of the definition of "Substantial change in services" and inserting in
2135 place thereof the following sentence:- Notwithstanding any other provisions to the contrary, the
2136 department may further define what constitutes a substantial change in service in regulations,
2137 including, but not limited to, any changes in its provision of ambulatory surgery services by any
2138 facility that provides ambulatory surgery.

2139 SECTION 61. Section 25C of chapter 111, as so appearing, is amended by striking out, in lines
2140 4 and 5, the words "or substantially change the service of such facility" and inserting in place
2141 thereof the following words:- ", substantially change the service of such facility, or transfer
2142 ownership of a facility that requires a determination of need as a condition of initial licensure.

2143 SECTION 62. Section 25C of chapter 111, as so appearing, is hereby amended by striking out,
2144 in lines 42 – 44, the words ", in any location other than a health care facility, as such term is
2145 defined in section twenty-five B" and inserting in place thereof the following words:- "or as
2146 determined by the department".

2147 SECTION 63. Section 25C of chapter 111, as so appearing, is hereby amended by striking out,
2148 in line 62, the words "magnetic resonance imaging equipment" and inserting in place thereof the
2149 following words:- "new technology"

2150 SECTION 64. Section 25C of chapter 111, as so appearing, is hereby further amended by
2151 striking out the fourth paragraph and inserting in place thereof the following paragraph:-"No
2152 person or agency of the commonwealth or any political subdivision thereof shall acquire for
2153 location in other than a health care facility a unit of medical, diagnostic, or therapeutic
2154 equipment, other than equipment used to provide an innovative service or which is a new
2155 technology, as such terms are defined in section 25B, with a fair market value in excess of
2156 $150,000 unless the person or agency notifies the department of the person's or agency's intent
2157 to acquire such equipment and of the use that will be made of the equipment. Such notice shall
2158 be made in writing and shall be received by the department at least 30 days before contractual
2159 arrangements are entered into to acquire the equipment with respect to which notice is given. A
2160 determination by the department of need therefor shall be required for any such acquisition (i) if
2161 the notice required by this paragraph is not filed in accordance with the requirements of this
2162 paragraph, and (ii) if the requirements for exemption under subsection (a) of section twenty-five
2163 C1/2; provided, however, that in no event shall any person who acquires a unit of new
2164 technology for location other than in a health care facility refer or influence any referrals of
2165 patients to said equipment, unless said person is a physician directly providing services with that
2166 equipment; provided, however, that for the purposes of this section, no public advertisement
2167 shall be deemed a referral or an influence of referrals; and provided, further, that any person who
2168 has an ownership interest in said equipment, whether direct or indirect, shall disclose said
2169 interest to patients utilizing said equipment in a conspicuous manner. ".

2170 SECTION 65. Section 25C of chapter 111, as so appearing, is hereby further amended by
2171 striking out paragraphs 5 through 7 inclusive, and inserting in place thereof the following 3
2172 paragraphs:—

2173 A determination of need shall be required for acquisition of a hospital by any person, agency of
2174 the commonwealth or political subdivision thereof. In making any such determination, the
2175 department may consider the financial capacity of the prospective licensee to operate the hospital
2176 in accordance with applicable laws, whether the transaction will create a significant effect on the
2177 availability or accessibility of health care services to the affected communities, the ability of the
2178 prospective owner to meet the additional requirements for licensure under section 51G as
2179 determined by the department, and the applicant's plan for the provision of community benefits,
2180 including the identification and provision of essential health services.

2181 The department, in making any determination of need, shall encourage appropriate allocation of
2182 private and public health care resources and the development of alternative or substitute methods
2183 of delivering health care services so that adequate health care services will be made reasonably
2184 available to every person within the commonwealth at the lowest reasonable aggregate cost,
2185 may impose terms and conditions as the department reasonably determines are necessary to
2186 achieve the purposes and intent of this section, including but not limited to maintenance of
2187 existing, or addition of new, services and may consider additional factors. The department may
2188 also recognize the special needs and circumstances of projects that (1) are essential to the
2189 conduct of research in basic biomedical or health care delivery areas or to the training of health
2190 care personnel, (2) are unlikely to result in any increase in the clinical bed capacity or outpatient
2191 load capacity of the facility, and (3) are unlikely to cause an increase in the total patient care
2192 charges of the facility to the public for health care services, supplies, and accommodations, as

2193 such charges shall be defined from time to time in accordance with section 5 of chapter 409 of
2194 the acts of 1976. Any determination of need shall be guided by the state health plan.

2195 Applications for such determination shall be filed with the department, together with such other
2196 forms and information as shall be prescribed by, or acceptable to, the department. A duplicate
2197 copy of any application together with supporting documentation therefor, shall be a public record
2198 and kept on file in the department. The department may require a public hearing on any
2199 application. A reasonable fee, established by the department, shall be paid upon the filing of such
2200 application; provided, that in no event shall such fee exceed one-fifth of one per cent of the
2201 capital expenditures, if any, proposed by the applicant or 0.2 per cent of the acquisition costs of a
2202 transfer of ownership.

2203 SECTION 66. Said chapter 111, as so appearing, is hereby further amended by inserting after
2204 section 25E the following section:—

2205 Section 25E½. (a) There shall be in the department a division of health planning, in this section
2206 called the division. The division shall develop a state health plan, and may amend the plan as
2207 necessary.

2208 (b) There shall be in the department a health planning council consisting of the commissioner or
2209 designee, the director of the office of Medicaid or designee, the executive director of the division
2210 of health care cost and quality or designee, the secretary of health and human services or
2211 designee, the director of the division, and 3 members appointed by the governor, of whom at
2212 least 1 shall be a health economist; at least 1 shall have experience in health policy and planning,
2213 and at least 1 shall have experience in health care market planning and service line analysis. The

2214 health planning council shall advise the division and shall oversee and issue the state health plan

2215 developed by the division.

2216 (c) The state health plan developed by the division shall include at least the following: (1) an

2217 inventory of current health care facilities that includes licensed beds, surgical capacity, numbers

2218 of technologies or equipment defined as innovative services or new technologies by the

2219 department, and all other services or supplies that are subject to determination of need, and (2) an

2220 assessment of the need for every such service or supply on a state-wide or regional basis

2221 including projections for such need for at least 5 years.

2222 (d) The department shall issue guidelines, rules, or regulations consistent with the state health

2223 plan for making determinations of need.

2224 SECTION 67. Section 25G of said chapter, as so appearing, is hereby amended by inserting at

2225 the end thereof the following sentence:—

2226 Any violation of such provisions also shall constitute grounds to refuse to accept, review or

2227 consider an application for a determination of need by the facility, its affiliates, including a

2228 parent, subsidiary umbrella organization or another facility in the same health system or

2229 organization; or grounds for additional terms and conditions on any subsequent application for a

2230 determination of need by the facility or its affiliates, including a parent, subsidiary, umbrella

2231 organization or another facility in the same health system or organization for a minimum of 5

2232 years.

2233 SECTION 68. Section 51G of chapter 111, as so appearing, is hereby amended, in line 38, after

2234 the words “or services,” the following words:- “conduct a public hearing on the closure of said

2235 essential services or of the hospital. The department shall”.

2236 SECTION 69. Section 51G of chapter 111, as so appearing, is hereby amended, in line 40, by
2237 striking out the word "area," and inserting in place thereof the following words:- "area and
2238 shall".

2239 SECTION 70. Section 51G of chapter 111, as so appearing, is hereby amended, in line 41, by
2240 striking out the words ", and" and inserting in place thereof the following words:- ". In order to".

2241 SECTION 71. Section 51G of chapter 111, as so appearing, is hereby amended, in line 44, by
2242 inserting after the word "services" the following words:- ", the department shall require the
2243 hospital to continue providing the essential service unless the department finds that such
2244 continuation would impose an undue financial burden on the hospital".

2245 SECTION 72. Section 51G of chapter 111, as so appearing, is hereby amend by inserting after
2246 paragraph (6) the following paragraph:-(7) Any violation of the requirements under this section
2247 also shall constitute grounds for refusing to grant or renew, modifying or revoking the license of
2248 a health care facility or of any part thereof; grounds to refuse to accept, review or consider an
2249 application for a determination of need by the facility, its affiliates, including a parent, subsidiary
2250 umbrella organization or another facility in the same health system or organization, or grounds
2251 for additional terms and conditions on any subsequent application for a determination of need by
2252 the facility or its affiliates, including a parent, subsidiary, umbrella organization or another
2253 facility in the same health system or organization for a minimum of five years.

2254 SECTION 73. The General Laws are hereby amended by inserting after chapter 118H the
2255 following chapter:—

2256 CHAPTER 118I. HEALTH INFORMATION TECHNOLOGY

2257 Section 1. As used in this chapter, the following words shall, unless the context clearly requires

2258 otherwise, have the following meanings:—

2259 “Division”, the division of health care cost and quality established under chapter 118G.

2260 “Electronic health record,” a longitudinal electronic record of patient health information

2261 generated by one or more encounters in any care delivery setting.

2262 “Electronic medical home,” the location of a patient’s electronic health record whether located,

2263 maintained or stored on a provider server, at a central storage repository, cloud storage, or any

2264 other storage and retrieval method or location.

2265 “Health information exchange,” an electronic platform enabling the transmission of healthcare-

2266 related data among providers, health care facilities, health information organizations and

2267 government agencies according to national standards, the reliable and secure transfer of data

2268 among diverse systems and access to and retrieval of data.

2269 Section 2. (a) There shall be established a health information technology council within the

2270 division. The council shall advise the division on the dissemination of health information

2271 technology across the commonwealth, including the deployment of electronic health records

2272 systems in all health care provider settings that are networked through a statewide health

2273 information exchange.

2274 (b) The council shall consist of 19 members, as follows: 1 shall be the executive director of the

2275 division, who shall serve as the chair; 1 shall be the secretary of health and human services; 1

2276 shall be the secretary of administration and finance or designee; 1 shall be the secretary of

2277 housing and economic development or designee; 1 shall be the director of the office of Medicaid

2278 or designee; 1 shall be the commissioner of public health or designee; and 13 shall be appointed
2279 by the governor, of whom at least 1 shall be an expert in health information technology, 1 shall
2280 be an expert in law and health policy, and 1 shall be an expert in health information privacy and
2281 security; 1 shall be from an academic medical center; 1 shall be from a community hospital; 1
2282 shall be from a community health center; 1 shall be from a long term care facility; 1 shall be
2283 from large physician group practice; 1 shall be from a small physician group practice; 1 shall
2284 represent health insurance carriers; and 3 additional members shall have experience or expertise
2285 in health information technology. The council may consult with parties, public or private, that it
2286 considers desirable in exercising its duties under this section, including persons with expertise
2287 and experience in the development and dissemination of electronic health records systems, and
2288 the implementation of electronic health record systems by small physician groups or ambulatory
2289 care providers, as well as persons representing organizations within the commonwealth
2290 interested in and affected by the development of networks and electronic health records systems,
2291 including, but not limited to, persons representing local public health agencies, licensed hospitals
2292 and other licensed facilities and providers, private purchasers, the medical and nursing
2293 professions, physicians and health insurers, the state quality improvement organization,
2294 academic and research institutions, consumer advisory organizations with expertise in health
2295 information technology and other stakeholders as identified by the secretary of health and human
2296 services. Appointive members of the council shall serve for terms of 2 years or until a successor
2297 is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

2298 Chapter 268A shall apply to all council members, except that the council may purchase from,
2299 sell to, borrow from, contract with or otherwise deal with any organization in which any council
2300 member is in anyway interested or involved; provided, however, that such interest or

2301 involvement shall be disclosed in advance to the council and recorded in the minutes of the
2302 proceedings of the council; and provided further, that no member shall be deemed to have
2303 violated section 4 of said chapter 268A because of his receipt of his usual and regular
2304 compensation from his employer during the time in which the member participates in the
2305 activities of the council.

2306 Section 3. (a) There shall be established within the division a department of health information
2307 technology. The executive director of the division shall appoint a qualified individual to serve as
2308 the director of the department, who shall be an employee of the division, report to the executive
2309 director and manage the affairs of the department. The department shall advance the
2310 dissemination of health information technology across the commonwealth, including the
2311 deployment of electronic health records systems in all health care provider settings that are
2312 networked through a statewide health information exchange.

2313 (b) The department shall have full authority to conduct procurements and enter into contracts for
2314 the purchase and development of any and all hardware or software in connection with carrying
2315 out the purposes of this act. The department shall have the full and exclusive authority over the
2316 technical aspects of the development, dissemination and implementation of health information
2317 technology in the commonwealth including the deployment of electronic health records systems
2318 in all provider settings that are networked through a fully interoperable statewide health
2319 information exchange; provided, however, that the division shall have the sole responsibility for
2320 determining any policy objectives of the health information exchange and other health
2321 information technology.

2322 Section 4. (a) The department, in consultation with the council, shall advance the dissemination
2323 of health information technology by: (i) ensuring the implementation and use of electronic health
2324 records systems by health care providers in order to improve health care delivery and
2325 coordination, reduce unwarranted treatment variation, eliminate wasteful paper-based processes,
2326 help facilitate chronic disease management initiatives and establish transparency; (ii) ensuring
2327 the creation and maintenance of a statewide interoperable electronic health information exchange
2328 that allows individual health care providers in all health care settings to exchange patient health
2329 information with other providers; and (iii) identifying and promoting an accelerated
2330 dissemination in the commonwealth of emerging health care technologies that have been
2331 developed and employed and that are expected to improve health care quality and lower health
2332 care costs, but that have not been widely implemented in the commonwealth.

2333 (b) In carrying out the purposes of this section, the department shall consult with various
2334 organizations of regional payers and providers involved in the development of a health
2335 information exchange in developing the statewide electronic records plan and annual updates and
2336 in designing, developing, disseminating and implementing health information technology.

2337 Section 5. (a) The director of the department shall prepare and annually update a statewide
2338 electronic health records and health information exchange implementation plan and an annual
2339 update thereto. Each plan shall contain a budget for the application of funds from the
2340 Massachusetts Health Information Technology Fund for use in implementing each such plan.
2341 The director shall submit such plans and updates, and associated budgets, to the division for its
2342 approval. Each such plan and the associated budget shall be subject to approval of the division.

2343 (b) Components of each such plan, as updated, shall be community-based implementation plans
2344 that assess a municipality's or region's readiness to implement and use electronic health record
2345 systems and an interoperable electronic health information exchange within the referral market
2346 for a defined patient population. Each such implementation plan shall address the development,
2347 implementation and dissemination of electronic health records systems among health care
2348 providers in the community or region, particularly providers, such as community health centers
2349 that serve underserved populations, including, but not limited to, racial, ethnic and linguistic
2350 minorities, uninsured persons, and areas with a high proportion of public payer care.

2351 (c) Each plan as updated shall: (i) allow seamless, secure electronic exchange of health
2352 information among health care providers, health plans and other authorized users; (ii) provide
2353 consumers with secure, electronic access to their own health information; (iii) meet all applicable
2354 federal and state privacy and security requirements, including requirements imposed by the
2355 Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American
2356 Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R.
2357 §§160, 162, 164 and 170.; (iv) meet standards for interoperability adopted by the division; (v)
2358 give patients the option of allowing only designated health care providers to disseminate their
2359 individually identifiable information; (vi) provide public health reporting capability as required
2360 under state law; and (vii) allow reporting of health information other than identifiable patient
2361 health information for purposes of such activities as the executive director of the division may
2362 from time to time consider necessary.

2363 (d) Each plan as updated shall be consistent with the mandatory compliance date set forth in
2364 section 9 for implementation of the health information exchange and all other requirements of
2365 this act.

2366 Section 6. The department shall: (i) contract with implementing organizations to facilitate a
2367 public-private partnership that includes representation from hospitals, physicians and other
2368 health care professionals, health insurers, employers and other health care purchasers, health data
2369 and service organizations, and consumer organizations and provide resources and support to
2370 recipients of grants awarded under section 15 to implement each program within the designated
2371 community pursuant to the implementation plan; (ii) certify and disburse funds to subcontractors,
2372 when necessary; (iii) provide technical assistance to facilitate successful practice, redesign,
2373 adoption of electronic health records, and utilization of care management strategies; (iv) ensure
2374 that electronic health records systems are fully interoperable and secure and that sensitive patient
2375 information is kept confidential by exclusively utilizing electronic health records products that
2376 are certified by the Certification Commission for Healthcare Information Technology; and (v)
2377 certify a group of subcontractors who shall provide the necessary hardware and software for
2378 system implementation. Before the department issues requests for proposals for contracts to be
2379 entered into pursuant to this section, the department's director shall consult with the council and
2380 the division with respect to the content of all such proposals. All contracts with implementing
2381 organizations entered into by the department must first be approved by the division.

2382 Section 7. Every patient shall have full and unrestricted access to his electronic health record at
2383 all times. The department shall develop and implement a method of providing each patient
2384 secure access to such patient’s electronic health record. Such methods may include, but are not
2385 limited to, assigning patient personal identification number and protected password access to
2386 their electronic health record, electronic access devices or cards and such other means as the
2387 department may determine.

2388 Section 8. Not later than January 1, 2017, the department shall complete the development and
2389 implementation of a method of health information data storage that will allow patients and
2390 providers the ability to access electronic health records and securely and accurately exchange
2391 electronic health record information as provided in this chapter. Such methods may include a
2392 central storage repository, cloud storage, storage on provider servers, a central information index
2393 and request router, or such other methods as the department shall determine; provided that any
2394 such means of storage and access developed by the department shall be fully secure and shall
2395 ensure compliance with all state and federal privacy requirements, including those imposed by
2396 the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American
2397 Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45
2398 C.F.R.§§160, 162 and 164.

2399 Section 9. (a) The department shall develop and implement no later than January 1, 2017, a fully
2400 interoperable information technology platform to support and enable a fully functional state wide
2401 health information exchange that secures the participation of all health care providers in the
2402 exchange. To ensure compliance, the division shall have the authority to impose penalties as
2403 provided in this section.

2404 (b) At a minimum, the health information exchange must enable the following capabilities:

2405 (i) The storage and maintenance of all electronic health records of a patient at the patient's
2406 electronic medical home;

2407 (ii) Allow providers to contemporaneously and securely transfer information and records
2408 regarding any medical event or encounter to the patient's electronic medical home;

2409 (iii) Allow providers to promptly and securely access and retrieve a patient's electronic

2410 medical record; and

2411 (iv) Allow patients access to their own medical record at all times.

2412 (b) The division is authorized to impose penalties for non-compliance by healthcare providers

2413 with the requirements of this section of up to $1 per day per member up to a maximum of 45

2414 days; provided, however, that the division may waive penalties for good cause shown, including

2415 lack of broadband internet access as provided in section 10. Penalties collected under this section

2416 shall be deposited into the wellness and prevention trust fund, as created in section 75 of chapter

2417 10.

2418 Section 10. If a provider is located in a geographic area of the commonwealth that does not have

2419 broadband internet access and, due to lack of such broadband internet access, such provider is

2420 unable to fully comply with the requirements of the health information exchange and any other

2421 health information technology requirements implemented by the department under this chapter,

2422 such provider may apply to the department for a temporary waiver as to any specific requirement

2423 with which it is unable to comply for such reason. If the department determines that the provider

2424 is unable to comply with a requirement due to the lack of broadband internet access, the division

2425 may grant a waiver of such requirement; provided, however, that, upon a determination by the

2426 division that broadband internet access has become available to such provider since the date of

2427 the grant of the waiver, the division shall notify such provider thereof. Within 180 days of such

2428 notice, such provider shall take such actions as are necessary to bring the provider into full

2429 compliance with the requirements of the health information exchange and any other health

2430 information technology requirements implemented by the division under this chapter.

2431 Section 11. There shall be established and set up on the books of the division the Massachusetts
2432 Health Information Technology Fund, hereinafter referred to as the fund, for the purpose of
2433 supporting the advancement of health information technology in the commonwealth, including,
2434 but not limited to, the full deployment of electronic health records. There shall be credited to the
2435 fund any appropriations, proceeds of any bonds or notes of the commonwealth issued for the
2436 purpose, or other monies authorized by the general court and designated thereto; any federal
2437 grants or loans; any private gifts, grants or donations made available; and any income derived
2438 from the investment of amounts credited to the fund. There shall be transferred to the fund any
2439 money in the E-Health Institute Fund as of the effective date of this act. The director of the
2440 division shall seek, to the greatest extent possible, private gifts, grants and donations to the fund.
2441 The division shall hold the fund in an account or accounts separate from other funds. The fund
2442 shall be administered by the executive director of the division without further appropriation;
2443 provided, however, that any disbursement or expenditure from the fund for grants or for
2444 contracts with implementing organizations, as provided in section 15, shall be approved by the
2445 division's board.. Amounts credited to the fund shall be available for reasonable expenditure by
2446 the department, subject to the approval of the division where such approval is required under this
2447 section, for such purposes as the department determines are necessary to support the
2448 dissemination and development of health information technology in the commonwealth,
2449 including, but not limited to, for the grant program established in section 15 and for contracts
2450 with implementing organizations provided for in section 6.

2451 Section 12. Any plan approved by the department and every grantee and implementing
2452 organization that receives monies for the adoption of health information technology shall:

2453 (1) establish a mechanism to allow patients to opt-in to the health information exchange and to
2454 opt-out at any time, including a separate opt-in mechanism relative to information pertaining to
2455 health conditions associated with the human immunodeficiency virus.

2456 (2) maintain identifiable health information in physically and technologically secure
2457 environments by means including, but not limited to: prohibiting the storage or transfer of
2458 unencrypted and non-password protected identifiable health information on portable data storage
2459 devices; requiring data encryption, unique alpha-numerical identifiers and password protection;
2460 and other methods to prevent unauthorized access to identifiable health information;

2461 (3) provide patients the option of, upon request, obtaining a list of individuals and entities that
2462 have accessed their identifiable health information;

2463 (4) develop and distribute to authorized users of the health information exchange and to
2464 prospective exchange participants, written guidelines addressing privacy, confidentiality and
2465 security of health information and inform individuals of what information about them is
2466 available, who may access their information, and the purposes for which their information may
2467 be accessed; and

2468 (5) ensure compliance with all state and federal privacy requirements, including those imposed
2469 by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American
2470 Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45
2471 C.F.R.§§160, 162 and 164.

2472 Section 13. In the event of an unauthorized access to or disclosure of individually identifiable
2473 patient health information by or through the statewide health information exchange or by or
2474 through any technology grantees or implementing organizations funded in whole or in part from

2475 the Massachusetts Health Information Technology Fund established pursuant to section 11, the
2476 operator of such exchange or grantee or contractor shall: (i) report the conditions of such
2477 unauthorized access or disclosure as required by the department; and (ii) provide notice, as
2478 defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days
2479 after such unauthorized access or disclosure, to any person whose patient health information may
2480 have been compromised as a result of such unauthorized access or disclosure, and shall report the
2481 conditions of such unauthorized access or disclosure. Any unauthorized access or disclosures
2482 shall be punishable by the civil penalties as set forth in subsection 18.

2483 Section 14. The ability of any provider to transfer or access all or any part of a patient's
2484 electronic health record under the provisions of this section shall be subject to the patient's
2485 election to participate in the electronic health information exchange as provided in section 12.
2486 Such ability shall also be subject to a separate required election to participate as to any
2487 information relating to human immunodeficiency virus status.

2488 Section 15. Funding for the department's activities shall be through the Massachusetts Health
2489 Information Technology Fund, established in section 11. The department shall develop
2490 mechanisms for funding health information technology, including grant and no interest loan
2491 programs as provided in this section and section 17 to assist health care providers with costs
2492 associated with health information technologies, including electronic health records systems, and
2493 coordinating with other electronic health records projects seeking federal reimbursement.

2494 The department shall pursue and maximize all opportunities to qualify for federal financial
2495 participation under the matching grant program established under the Health Information
2496 Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment

2497 Act of 2009, P.L. 111-5. The department shall consult with the office of Medicaid to maximize
2498 all opportunities to qualify any expenditure for any other federal financial participation.
2499 Applications for funding shall be in the form and manner determined by the department, and
2500 shall include the information and assurances required by the department. The department may
2501 consider, as a condition for awarding grants, the grantee's financial participation and any other
2502 factors it deems relevant.

2503 All grants shall be recommended by the department and subsequently approved by the division
2504 in consultation with the council. The director of the department shall work with implementing
2505 organizations to oversee the grant-making process as it relates to an implementing organization's
2506 responsibilities under its contract with the division. Each recipient of monies from this program
2507 shall: (i) capture and report certain quality improvement data, as determined by the division; (ii)
2508 implement the system fully, including all clinical features, not later than the second year of the
2509 grant; and (iii) make use of the system's full range of features.

2510 Section 16. The department shall file an annual report, not later than January 30, with the joint
2511 committee on health care financing, and the house and senate committees on ways and means
2512 concerning the activities of the department in general and, in particular, describing the progress
2513 to date in implementing a statewide electronic health records system and recommending such
2514 further legislative action as it deems appropriate.

2515 Section 17. (a) The state comptroller shall establish and set up on the books of the
2516 commonwealth the Massachusetts health information technology revolving loan fund, hereinafter
2517 referred to as the fund, for the purpose of providing loan assistance to healthcare providers, as
2518 defined in section 1 of chapter 111, to pay the costs associated with compliance with state and

2519 federal requirements relative to the implementation of health care information technology in the
2520 commonwealth, including, but not limited to, the costs of purchasing, installing and
2521 implementing of electronic health records systems and other health information technology
2522 required by state or federal law. There shall be credited to the fund any appropriations, proceeds
2523 of any bonds or notes of the commonwealth issued for the purpose, or other monies authorized
2524 by the general court and designated thereto; any federal grants or loans; any private gifts, grants
2525 or donations made available; and any income derived from the investment of amounts credited to
2526 the fund. The division shall pursue and maximize all opportunities to qualify for federal financial
2527 participation under the matching grant program established under §3013 of the Health
2528 Information Technology for Economic and Clinical Health Act of the American Recovery and
2529 Reinvestment Act of 2009, P.L. 111-5. The department shall seek, to the greatest extent possible,
2530 private gifts, grants and donations to the fund. The fund shall be held in an account or accounts
2531 separate from other funds. The fund shall be administered by the director of the department
2532 without further appropriation; provided, however, that any disbursement or expenditure from the
2533 fund for loans to healthcare providers shall be approved by the division. Amounts credited to the
2534 fund shall be available for reasonable expenditure by the department, subject to the approval of
2535 the division, for such purposes as the department determines are necessary to support the
2536 dissemination and development of health information technology in the commonwealth,
2537 including, but not limited to, the loan program established in this section. Any funds remaining
2538 in the fund at the end of a fiscal year shall be carried forward into the following fiscal year and
2539 shall remain available for expenditure without further appropriation.

2540 (b) The department shall make available zero interest loan funding from the Massachusetts
2541 health information technology revolving loan fund to healthcare providers, as defined in section

2542 1 of chapter 111, to assist with the development and implementation of an interoperable health

2543 information technology system that meets all federal and state requirements. The department

2544 shall make such loans available through banks approved to do business in the commonwealth by

2545 the division of banks. The department shall enter into agreements with such lenders to make

2546 loans. The department, in consultation with the state treasurer, shall develop a lender partnership

2547 program and lender agreement that requires, at a minimum, (i) that a bank must be adequately

2548 capitalized, consistent with the requirements of 209 CMR 47.00 et seq. and as defined under the

2549 prompt corrective action provisions of the Federal Deposit Insurance Act, 12 U.S.C. § 1831(o),

2550 and the Federal Deposit Insurance Corporation's Capital Adequacy Regulations, 12 CFR §

2551 325.103; (ii) the department shall specify lending standards, including without limitation, those

2552 for determining eligibility, including the eligibility standards set forth in this subsection, size and

2553 number of loans, and (iii) that all loans made under the program must be zero interest loans

2554 provided, however, .that any such program may provide for reasonable application and

2555 administrative fees to be paid to lending banks under the program. A reasonable amount of

2556 administrative costs may be expended annually from the fund for the administration of the

2557 program. Any application or other fees imposed and collected under this program shall be

2558 deposited in the Massachusetts health information technology revolving loan fund for the

2559 duration of the loan program. The department may make such adjustments as are necessary to

2560 loan applications to account for reimbursements received under any other state or federal

2561 programs. To be eligible for a loan under this section, a healthcare provider, at a minimum, must

2562 provide the participating lending institution with the following information: (1) the amount of the

2563 loan requested and a description of the purpose or project for which the loan proceeds will be

2564 used; (2) a price quote from a vendor; (3) a description of the health care provider/entities and

2565 other groups participating in the project; (4) evidence of financial condition and ability to repay
2566 the loan; and (5) a description of how the loan funds will be used to bring the healthcare provider
2567 into compliance with federal and state requirements. Loans shall be repaid over a five-year term
2568 according to a schedule to be established through division regulations. The attorney general shall
2569 enforce collection of any loans in default.

2570 The division shall promulgate regulations necessary for the operation of this program.

2571 Section 18. Unauthorized access to or disclosure of individually identifiable patient health
2572 information by or through the statewide health information exchange or by or through any
2573 technology grantees or implementing organizations funded in whole or in part from the
2574 Massachusetts Health Information Technology Fund, or any associated businesses managing or
2575 in possession of such information, established pursuant to section 11, the operator of such
2576 exchange or grantee or contractor shall be subject to the following fines and penalties. The
2577 division shall promulgate regulations to assess fair and reasonable fines or penalties.

2578 Section 19. The division shall adopt regulations requiring hospitals, clinics, and health care
2579 networks to implement evidence-based best practice clinical decision support tools for the
2580 ordering provider of advanced diagnostic imaging services by January 1, 2017. The clinical
2581 decision support guidelines and protocols developed by the division shall encourage the use of
2582 electronic order entry for advanced imaging services using web-based interfacing between
2583 decision support tools and the software used for electronic order entry, whether it be the
2584 electronic health record system or other health information technology tool. The use of such
2585 decision support tools shall meet the privacy and security standards promulgated pursuant to the
2586 federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-119).

2587 For the purpose of this section, advanced diagnostic imaging services shall include computerized

2588 tomography, magnetic resonance imaging, magnetic resonance angiography, positive emission

2589 tomography, cardiac imaging, ultrasound diagnostic imaging, and such other imaging services as

2590 may be determined by the division.

2591 SECTION 74. Section 2 of chapter 118I is hereby repealed.

2592 SECTION 75. The General Laws are hereby amended by inserting after chapter 118I the

2593 following chapter:-

2594 CHAPTER 118J. ACCOUNTABLE CARE ORGANIZATIONS

2595 Section 1. As used in this chapter, the following words shall, unless the context clearly requires

2596 otherwise, have the following meanings:—

2597 "Accountable Care Organization" or "ACO", an entity comprised of health care providers

2598 organized into an integrated organization that accepts shared risk for the cost and quality of a

2599 patient's well being.

2600 "ACO Participant", a health care provider that either integrates or contracts with an ACO to

2601 provide services to ACO patients.

2602 "ACO Patient", an individual who chooses or is attributed to an ACO for his course of medical

2603 treatment, for whom such services are paid by the payer to the ACO.

2604 "Alternative Payment Methodology", methods of payment that are used to reimburse for

2605 services. These types of payments may include, but not limited to global payments, shared

2606 savings arrangements, bundled payments, and episodic payments.

2607 “Division”, the division of health care cost and quality, as enabled in chapter 118G

2608 “Executive Director”, the executive director of the division of health care cost and quality, as
2609 enabled in chapter 118G

2610 “Health Care Provider”, a provider of medical of health services and any other person or
2611 organization, including ACO, that furnishes, bills, or is paid for health care service delivery in
2612 the normal course of business.

2613 “Office of patient protection”, the office within the division of health care cost and quality
2614 established under section 65 of chapter 118G.

2615 “Patient Centered Medical Home”, a model of health care delivery designed to provide a patient
2616 with a single point of coordination for all their health care, including primary, specialty, post-
2617 acute and chronic care, which is (a) patient-centered; (b) comprehensive, integrated and
2618 continuous; and (c) delivered by a team of health care professionals to manage a patient’s care,
2619 reduce fragmentation, and improve patient outcomes.

2620 “Payer”, any entity, other than an individual, that pays providers or ACOs for the provision of
2621 health care services. It shall include both governmental and private entities, but excludes ERISA
2622 plans.

2623 “Physician”, a medical doctor licensed to practice medicine in the commonwealth.

2624 “Primary Care Physician”, a physician who has a primary specialty designation of internal
2625 medicine, general practice, family practice, pediatric practice or geriatric practice.

2626 Section 2. (a) The division shall be responsible for licensing of ACOs. The license shall be
2627 issued for a term of 2 years and renewable under like terms. The ACO shall be in compliance

2628 with all state and federal laws such as the Americans with Disabilities Act, Health Information
2629 Privacy and Accountability Act, and Patient Protection and Affordable Care Act. The division
2630 shall develop the process for licensing ACOs.

2631 (b) A licensed ACO shall, at a minimum, meet the following:

2632 (1) Be a separate legal entity as required in Section 3;

2633 (2) Submit a collaborative care plan as defined in Section 4;

2634 (3) Meet the functional capabilities under Section 6;

2635 (4) Have a governance structure under Section 7;

2636 (5) Meet the criteria for size under Section 8;

2637 (6) Obtain interoperable health information technology under Section 9;

2638 (7) Meet the quality reporting requirements under Section 10;

2639 (8) Obtain a risk certificate from the Division of Insurance as defined by Section 12;

2640 (9) Create internal consumer protection guidelines as defined in Section 13; and

2641 (10) Meet pricing reporting requirements under Section 15.

2642 (c) The division may include additional requirements for ACO licensure.

2643 (d) No later than 30 days after an application has been filed, the division may require the ACO
2644 applicant to provide additional information to complete or supplement the filing.

2645 (e) Within 45 days of receipt of a complete application, the division shall complete its review of
2646 the application and send written notice to the ACO, with a copy to the division of insurance,
2647 explaining its decision to: (1) issue the license as applied for, (2) reject the application for failure
2648 to comply with the requirements of the application process, with instructions that the application
2649 may be resubmitted within 10 days; or (3) deny the application.

2650 (f) Any ACO's whose application has been rejected or denied may request an adjudicatory
2651 hearing pursuant to chapter 30A within 21 days of the division's decision. The division shall
2652 notify the attorney general and the division of insurance upon receipt of such hearing request.
2653 Said hearing shall be conducted within 30 days of the division's receipt of the hearing request.
2654 The attorney general may intervene in a hearing under this subsection and may require the
2655 production of additional information or testimony. The commissioner shall issue a written
2656 decision within 30 days of the conclusion of the hearing.

2657 (g) An ACO aggrieved by said written decision may, within 20 days of said decision, file a
2658 petition for review in the Suffolk superior court. Review by the supreme judicial court on the
2659 merits shall be limited to the record of the proceedings before the commissioner and shall be
2660 based upon the standards set forth in paragraph (7) of section 14 of chapter 30A.

2661 Section 3. An ACO shall be incorporated or registered in the commonwealth.

2662 Section 4. ACOs shall accept and share among their ACO participants responsibility for the
2663 delivery, management, quality, and cost of the provision of at least all integrated health care
2664 services, as such terms are defined by the division's authority under section 6, to ACO patients.
2665 The ACO shall submit a collaborative care plan for integrating health care and mental health
2666 services. The plan shall include and describe the minimal functional capabilities as defined in

2667 section 6. The division may reject a collaborative care plan if it fails to meet the minimum
2668 benefits or significantly fails to meet to goal of reducing health care costs.

2669 Section 5. ACOs shall be compensated by an alternative payment methodology for each ACO
2670 patient receiving services through the ACO, in accordance with this chapter and any regulations
2671 adopted by division as consistent as possible with federal law, regulations and rules.

2672 Section 6. The division shall have the authority to determine the minimum services offered by an
2673 ACO. The minimum services shall be promulgated in regulation. ACOs shall, at a minimum,
2674 provide or obtain through contractual arrangements the following functional capacities:

2675 (a) Clinical service coordination, management, and delivery functions, including the ability to
2676 provide integrated health care services through its ACO participant network in accordance with
2677 the principles of a patient centered medical home. Provided that clinical service coordination
2678 may be managed by a physician, a nurse practitioner, a registered nurse, physician assistant, or
2679 social worker.

2680 (b) Population management functions, including health information technology and data analysis
2681 tools to provide at least: (1) patient-specific encounter data and (2) management reports on
2682 aggregate data.

2683 (c) Financial management capabilities, including but not limited to the management of claims
2684 processing and payment functions for ACO participants.

2685 (d) Contract management capabilities, including but not limited to ACO participant contracting
2686 and management functions.

2687 (e) Quality measure competence, including but not limited to the ability to measure and report
2688 performance relative to established measures of quality and performance under standard quality
2689 measures as determined under section 10.

2690 (f) Provider and provider communications functions.

2691 (g) The ability to provide chronic disease management either internally within the ACO or by
2692 contractual agreement.

2693 (h) The ability to provide behavioral health services either internally within the ACO or by
2694 contractual agreement.

2695 (i) The ability to engage patients in shared decision making processes on long-term-care and
2696 supports and palliative care.

2697 (j) Contract with providers for any other medically necessary, but unavailable within the ACO,
2698 services or provide the patient with the ability to receive these services outside of the ACO.

2699 Section 7. (a) An ACO's organizational structure shall include a governance body, executive
2700 officer, and a medical director.

2701 (b) The governance body shall be identifiable and have the authority to execute functions for the
2702 following:

2703 (1) The governance body shall be responsible for oversight and strategic direction of the ACO,
2704 holding the management accountable for the ACO's activities;

2705 (2) The governance body shall have a transparent governing process;

2706 (3) The governance body members shall have a fiduciary duty and must act consistently with that

2707 fiduciary duty;

2708 (4) The governance body shall be separate and unique to the ACO in cases where the ACO

2709 comprises of multiple, otherwise independent ACO participants; and

2710 (5) If the ACO is an existing entity, the governing body may be the same as the existing entity

2711 provided it satisfies the other requirements of this section.

2712 (c) The governance body shall adhere to the following rules:

2713 (1) At least 75% of the body’s control shall be held by ACO participants;

2714 (2) The members of the governance body may serve in a similar or complementary manner for

2715 an ACO participant;

2716 (3) Members of the governance body shall not have a financial conflict of interest;

2717 (4) The governance body shall include at least one patient who does not have a financial conflict

2718 of interest with the ACO; and

2719 (5) The division shall have the discretion to allow a waiver and shall promulgate regulations for

2720 the possibility of waiving any of these requirements.

2721 (d) The executive officer shall be responsible for the administrative and operational systems to

2722 align the ACO with the goals of improving access, improving quality and reducing costs. The

2723 executive officer may be an executive, officer, manager, or general partner. The executive officer

2724 shall consult with the medical director to ensure care coordination and quality.

2725 (e) The medical director shall be responsible for the clinical management and oversight of the

2726 ACO. The medical director shall be a board-certified and licensed physician in the

2727 commonwealth. The medical director shall be an active ACO participant who is physically

2728 present on a regular basis at any clinic, office, or other location participating in the ACO.

2729 Section 8. (a) An ACO shall have a minimum of 15,000 covered lives. A patient shall voluntarily

2730 select to join an ACO and shall count as a covered life for that ACO. An ACO may not exclude a

2731 patient who receives coverage through a program offered by the division of medical assistance.

2732 (b) An ACO shall have a cap of 400,000 covered lives. They may waive this requirement under

2733 the following conditions:

2734 (1) The attorney general makes an annual determination that the size would not foster anti-

2735 competitive behavior;

2736 (2) The ACO demonstrates an improvement in quality to the division; and

2737 (3) The ACO shows a reduction in total medical expenses to the division.

2738 (c) The division, in consultation with the division of insurance, shall create an annual open

2739 enrollment period for a patient to join an ACO. This period shall last no less than 1 month and no

2740 longer than 2 months. The division shall allow a patient to switch an ACO once within the first 3

2741 months of coverage in the initial ACO.

2742 Section 9. The ACO shall have an interoperable electronic medical record system available for

2743 ACO participants to coordinate care, share information and electronic prescribing capabilities by

2744 January 1, 2017. The division, in consultation with the Health Information Technology Council

2745 for technical advice, shall promulgate regulations related to electronic medical records including,

2746 but not limited to the standards of interoperability, care coordination tools, information processes
2747 or electronic prescribing standards.

2748 Section 10. (a) The division shall use the standard quality measure set and set minimum
2749 standards that ACOs are responsible for maintaining.

2750 (b) ACOs shall report the quality measures to the division on a semi-annual basis. Failure to
2751 submit a timely report shall result in a fine of $100 per day up to $5,000 per missed reporting
2752 period.

2753 (c) The division may conduct an on-site audit of the ACO's quality reporting no more than twice
2754 a year unless the division deems additional audits are required in the interest of public safety.

2755 (d) The division may fine ACOs up to $1 per attributed member for failure to meet quality
2756 measures in each reporting period. The ACO shall create and file a quality corrective action plan
2757 with the division if it fails to meet the quality measures in any given reporting period. The
2758 division may revoke an ACO's license if 1) it fails to timely file its corrective action plan, 2)
2759 fails to follow the corrective action plan in a following reporting period, or 3) it fails to meet the
2760 quality measures for 3 consecutive reporting periods.

2761 Section 11. (a) Notwithstanding any other law or regulation to the contrary, the ACO shall be
2762 held liable up to the amount of $500,000 for any medical malpractice based claim against an
2763 ACO participant acting on behalf of the ACO.

2764 (b) Interest on a legal judgment against an ACO shall be assessed in accordance to section 60K
2765 of chapter 231.

2766 Section 12. The commissioner of insurance shall make a determination that an ACO has
2767 adequate reserves to meet their risk arrangements. The commissioner of insurance shall
2768 promulgate regulations to ensure the viability of an ACO for risks including, but not limited to
2769 global payment risk or enterprise liability based risks. Upon the satisfaction of the commissioner
2770 of insurance, the division of insurance shall submit a certificate of approval to the division.

2771 Section 13. The division shall create guidelines for ACOs to create internal appeals plans for
2772 denial of care. These guidelines shall include the clear articulation of the appellate stages, timing
2773 requirements for each stage of appeal, the process for second opinions to occur outside of the
2774 ACO. The final decision within the ACO shall be completed within 14 days after the filing of a
2775 complaint by a patient. The division may require ACOs to create an ombudsman office or similar
2776 office for the protection of patients. Once appeals within the ACO have been exhausted
2777 internally, the claims shall be appealable to the office of patient protection.

2778 Section 14. Every ACO shall develop and file an internal appeals plan according to section 13.
2779 The division shall approve each plan. The plan shall be a part of a membership packet for newly
2780 enrolled individuals.

2781 Section 15. The division shall require ACOs to report pricing of services by its ACO
2782 participants. The division shall require the reporting of these prices to inform the consumer under
2783 section 50 of chapter 118G. ACO participants shall have the ability to provide patients with
2784 relevant price information when contemplating their care and potential referrals.

2785 SECTION 76. Chapter 149 of the General Laws, as so appearing, is hereby amended by striking
2786 out section 188 and inserting in place thereof the following section:—

2787 Section 188. (a) As used in this section, the following words, unless the context clearly requires

2788 otherwise, shall have the following meanings:--

2789 “Authority”, the commonwealth health insurance connector authority.

2790 "Contributing employer", an employer that offers a group health plan, as defined in 26 U.S.C.

2791 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as defined

2792 in regulation by the division of health care finance and policy.

2793 "Department", the department of unemployment assistance.

2794 "Employer", an employing unit as defined in section 1 of chapter 151A or in section 1 of chapter

2795 152.

2796 "Employee", any individual employed by an employer subject to this chapter for at least 1

2797 month, provided that for the purpose of this section self-employed individuals shall not be

2798 considered employees.

2799 (b) For the purpose of more equitably distributing the costs of health care provided to uninsured

2800 residents of the commonwealth, each employer that (i) employs 11 or more full-time equivalent

2801 employees in the commonwealth and (ii) is not a contributing employer shall pay a per-employee

2802 contribution at a time and in a manner prescribed by the director of unemployment assistance, in

2803 this section called the fair share employer contribution. This contribution shall be pro-rated by a

2804 fraction which shall not exceed 1, the numerator of which is the number of hours worked in the

2805 quarter by all of the employer's employees and the denominator of which is the product of the

2806 number of employees employed by an employer during that quarter multiplied by 500 hours.

2807 (c) The executive director of the authority, shall, in consultation with the director of
2808 unemployment assistance, annually determine the fair share employer contribution rate based on
2809 the best available data and under the following provisions:--

2810 (1) The per-user share of private sector liability shall be calculated annually by dividing the sum
2811 of hospital liability and third-party payor liability for uncompensated care, as defined by law, by
2812 the total number of individuals in the most recently completed fiscal year whose care was
2813 reimbursed in whole or in part by the uncompensated care pool, or any successor thereto.

2814 (2) The total number of employees in the most recent fiscal year on whose behalf health care
2815 services were reimbursed in whole or in part by the uncompensated care pool, or any successor
2816 thereto, shall be calculated. In calculating this number, the authority shall use all resources
2817 available to enable it to determine the employment status of individuals for whom
2818 reimbursements were made, including quarterly wage reports maintained by the department of
2819 revenue.

2820 (3) The total number of employees as calculated in paragraph (2) shall be adjusted by
2821 multiplying that number by the percentage of employers in the commonwealth that are not
2822 contributing employers, as determined by the authority.

2823 (4) The total cost of liability associated with employees of non- contributing employers shall be
2824 determined by multiplying the number of employees, as calculated in paragraph (3) by the per-
2825 user share of private sector liability as calculated in paragraph (1).

2826 (5) The fair share employer contribution shall be calculated by dividing the total cost of liability
2827 as calculated in paragraph (4) by the total number of employees of employers that are not
2828 contributing employers, as determined by the authority.

2829 (6) The fair share employer contribution, as determined in paragraph (5) shall be adjusted
2830 annually to reflect medical inflation, using an appropriate index as determined by the authority.

2831 (7) The total dollar amount of health care services provided by physicians to non-elderly,
2832 uninsured residents of the commonwealth for which no reimbursement is made from the Health
2833 Safety Net Trust Fund shall be calculated using a survey of physicians or other data source that
2834 the authority determines is most accurate.

2835 (8) The per-employee cost of uncompensated physician care shall be calculated by dividing the
2836 dollar amount of such services, as calculated in paragraph (7) by the total number of employees
2837 of contributing employers in the commonwealth, as estimated by the division using the most
2838 accurate data source available, as determined by the authority.

2839 (9) The annual fair share employer contribution shall be calculated by adding the fair share
2840 employer contribution as calculated in paragraph (6) and the per-employee cost of unreimbursed
2841 physician care, as calculated in paragraph (8).

2842 (10) Notwithstanding this section, the total annual fair share employer contribution shall not
2843 exceed $295 per employee which may be made in a single payment, or in equal amounts semi-
2844 annually or quarterly, at the employer's discretion.

2845 (d) The director of unemployment assistance shall determine quarterly each employer's liability
2846 for its fair share employer contribution. The director shall assess each employer liable for a fair
2847 share employer contribution in a quarter an amount based on 25 per cent of the annual fair share
2848 employer contribution rate applicable to that quarterly period and shall implement penalties for
2849 employers who fail to make contributions as required by this section. In order to reduce the
2850 administrative costs of collection of contributions, the director shall, to the extent possible, use

2851 any existing procedures that have been implemented by the department of unemployment
2852 assistance to make similar collections. Amounts collected pursuant to this section shall be
2853 deposited in the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29.
2854 Before depositing the amounts, the director may deduct all administrative costs incurred by the
2855 department of unemployment assistance as a result of this section, including an amount as
2856 determined by the United States Secretary of Labor in accordance with federal cost rules. Except
2857 where inconsistent with this section, the terms and conditions of chapter 151A which are
2858 applicable to the payment and collection of contributions shall apply to the same extent to the
2859 payment and collection of any obligation under this section. The department of unemployment
2860 assistance shall promulgate regulations necessary to implement this section.

2861 (e) In promulgating regulations defining the term "contribution" under this section, no proposed
2862 regulation by the authority, except an emergency regulation, shall take effect until 60 days after
2863 the proposed regulations have been transmitted to the joint committees on health care financing
2864 and financial services.

2865 SECTION 77. Section 1 of chapter 175 of the General Laws is hereby amended by inserting
2866 after the definition of "unearned premiums" the following definition:—

2867 "Wellness Program", a wellness program receiving a seal of approval under section 206A of
2868 chapter 111.

2869 SECTION 78. Section 108 of chapter 175 is hereby amended by inserting after clause 12, the
2870 following clause:—

2871 13. Any policy of accident and sickness shall include a premium rate adjustment based on
2872 employee participation in a wellness program.

2873 SECTION 79. Chapter 175 of the General Laws is hereby amended by inserting after section
2874 108J the following 2 sections:-

2875 Section 108K. Pursuant to section 50 of chapter 118G, carriers shall provide a toll-free number
2876 and website that enables consumers to request and obtain from the carrier in real time the
2877 maximum estimated amount the insured will be responsible to pay for a proposed admission,
2878 procedure or service that is a medically necessary covered benefit , based on the information
2879 available to the carrier at the time the request is made, including any copayment, deductible,
2880 coinsurance or other out of pocket amount for any health care benefits.

2881 Section 108L. Pursuant to section 50 of chapter 118G, carriers shall disclose patient-level data
2882 including, but not limited to, health care service utilization, medical expenses, demographics,
2883 and where services are being provided, to all providers in their network, provided that data shall
2884 be limited to patients treated by that provider, so as to aid providers in managing the care of their
2885 own patient panel.

2886 SECTION 80. Chapter 175 of the General Laws is hereby amended by inserting after section
2887 226 the following 2 sections:-

2888 Section 227. As used in this section, the following words shall have the following meanings:

2889 "Self-insured group," a self-insured or self-funded employer group health plan.

2890 "Third-party administrator," an entity that administers payments for health care services on
2891 behalf of a client plan in exchange for an administrative fee.

2892 Pursuant to section 50 of chapter 118G, every third-party administrator shall disclose to their
2893 self-insured group clients contracted prices and quality of services of in-network providers.

2894 Section 228.Carriers shall attribute every member to a primary care provider.

2895 SECTION 81. Chapter 176A of the General Laws is hereby amended by inserting after section
2896 34 the following 3 sections:—

2897 Section 35. Pursuant to section 50 of chapter 118G, every non-profit hospital service corporation
2898 shall provide a toll-free number and website that enables consumers to request and obtain from
2899 the non-profit hospital service corporation in real time the maximum estimated amount the
2900 insured will be responsible to pay for a proposed admission, procedure or service that is a
2901 medically necessary covered benefit, based on the information available to the carrier at the time
2902 the request is made, including any copayment, deductible, coinsurance or other out of pocket
2903 amount for any health care benefits.

2904 Section 36. Every non-profit hospital service corporation shall attribute every member to a
2905 primary care provider.

2906 Section 37. Pursuant to section 50 of chapter 118G, every non-profit hospital service corporation
2907 shall disclose patient-level data including, but not limited to, health care service utilization,
2908 medical expenses, demographics, and where services are being provided, to all providers in their
2909 network, provided that data shall be limited to patients treated by that provider, so as to aid
2910 providers in managing the care of their own patient panel.

2911 SECTION 82. Chapter 176B of the General Laws is hereby amended by inserting after section
2912 22 the following 3 sections:-

2913 Section 23. Pursuant to section 50 of chapter 118G, every medical service corporation shall
2914 provide a toll-free number and website that enables consumers to request and obtain from the

2915 medical service corporation in real time the maximum estimated amount the insured will be
2916 responsible to pay for a proposed admission, procedure or service that is a medically necessary
2917 covered benefit, based on the information available to the carrier at the time the request is made,
2918 including any copayment, deductible, coinsurance or other out of pocket amount for any health
2919 care benefits.

2920 Section 24. Every medical service corporation shall attribute every member to a primary care
2921 provider.

2922 Section 25. Pursuant to section 50 of chapter 118G, every medical service corporation shall
2923 disclose patient-level data including, but not limited to, health care service utilization, medical
2924 expenses, demographics, and where services are being provided, to all providers in their
2925 network, provided that data shall be limited to patients treated by that provider, so as to aid
2926 providers in managing the care of their own patient panel.

2927 SECTION 83. Chapter 176G of the General Laws is hereby amended by inserting after section
2928 30 the following 3 sections:—

2929 Section 31. Pursuant to section 50 of chapter 118G, every health maintenance organization shall
2930 provide a toll-free number and website that enables consumers to request and obtain from the
2931 health maintenance organization in real time the maximum estimated amount the insured will be
2932 responsible to pay for a proposed admission, procedure or service that is a medically necessary
2933 covered benefit, based on the information available to the carrier at the time the request is made,
2934 including any copayment, deductible, coinsurance or other out of pocket amount for any health
2935 care benefits.

2936 Section 32. Every health maintenance organization shall attribute every member to a primary
2937 care provider.

2938 Section 33. Pursuant to section 50 of chapter 118G, every health maintenance organization shall
2939 disclose patient-level data including, but not limited to, health care service utilization, medical
2940 expenses, demographics, and where services are being provided, to all providers in their
2941 network, provided that data shall be limited to patients treated by that provider, so as to aid
2942 providers in managing the care of their own patient panel.

2943 SECTION 84. Paragraph (5) of subsection (a) of section 3 of chapter 176J, as appearing in the
2944 official 2010 edition, is hereby amended by striking out, in line 59, the word “may” and inserting
2945 in place thereof the following word:—“shall”.

2946 SECTION 85. Subsection (a) of section 11 of chapter 176J, as appearing in the 2010 edition, is
2947 hereby amended by inserting, in line 60, after the word “providers” the following clause:—,
2948 smart tiering plan in which health services are tiered and member cost sharing is based on the tier
2949 placement of the services,

2950 SECTION 86. Subsection (b) of section 11 of chapter 176J is hereby amended at the end of the
2951 first paragraph by adding the following 2 sentences:—

2952 Smart tiering plans may take into account the number of services performed each year by the
2953 provider. For smart tiering plans, if a medically necessary and covered service is available at
2954 only one facility in the state, as determined by the division of health care cost and quality, that
2955 service shall not be placed into the most expensive cost-sharing tier.

2956 SECTION 87. Section 11 of Chapter 176J is hereby amended by inserting after subsection (g)
2957 the following new 3 subsections:—

2958 (h) A smart tiering plan shall be a tiering product, which offers a cost-sharing differential based
2959 on services rather than facilities providing services. A service covered in a smart tiering plan
2960 may be reimbursed through bundled payments for acute and chronic diseases.

2961 (i) The division shall review smart tiering plans in a manner consistent with other products
2962 offered in the commonwealth. The division may disapprove a smart tiering plan if it determines
2963 that the carrier differentiated cost-sharing obligations solely based on the provider. There shall be
2964 a rebuttable presumption that a plan has violated this subsection if the cost-sharing obligation for
2965 all services provided by a provider, including health care facility, accountable care organization,
2966 patient centered medical home, or provider organization is the same.

2967 (j) The commissioner when developing smart tiering plans shall promote the following goals: 1)
2968 smart tiering plans should avoid creating consumer confusion, 2) it should minimize the
2969 administrative burdens on payers and providers in implementing smart tiering plans, 3) it should
2970 allow patients to get their services in the proper locations.

2971 SECTION 88. Section 11 of chapter 176J, as so appearing, is hereby amended by striking out, in
2972 line 13, the figure “12” and inserting in place thereof the following figure:—16

2973 SECTION 89. Section 11 of chapter 176J, as so appearing, is hereby amended by striking out, in
2974 line , the figure “12” and inserting in place thereof the following figure:—16

2975 SECTION 90. Section 11 of chapter 176J, as appearing, is hereby amended by inserting the
2976 following sentence at the end of subsection (a):—The board of the division shall determine the
2977 base rate discount on an annual basis.

2978 SECTION 91. Chapter 176J of the General Laws is hereby amended by inserting after section
2979 13 the following 3 sections:-

2980 Section 14. Pursuant to section 50 of chapter 118G, carriers shall provide a toll-free number and
2981 website that enables consumers to request and obtain from the carrier in real time the maximum
2982 estimated amount the insured will be responsible to pay for a proposed admission, procedure or
2983 service that is a medically necessary covered benefit, based on the information available to the
2984 carrier at the time the request is made, including any copayment, deductible, coinsurance or other
2985 out of pocket amount for any health care benefits.

2986 Section 15. Carriers shall attribute every member to a primary care provider.

2987 Section 16. Pursuant to section 50 of chapter 118G, every carrier shall disclose patient-level data
2988 including, but not limited to, health care service utilization, medical expenses, demographics,
2989 and where services are being provided, to all providers in their network, provided that data shall
2990 be limited to patients treated by that provider, so as to aid providers in managing the care of their
2991 own patient panel.

2992 SECTION 92. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby
2993 amended by inserting after the definition of “Adverse determination” the following definition:—

2994 “Allowed amount”, the contractually agreed upon amount paid by a carrier to a health care
2995 provider for health care services.

2996 SECTION 93. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby
2997 amended by inserting after the definition of "Person" the following definition:-

2998 "Primary care provider", a health care professional qualified to provide general medical care for
2999 common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
3000 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
3001 maintains continuity of care within the scope of practice.

3002 SECTION 94. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby further
3003 amended by inserting after the definition of "Health care services" the following new
3004 definition:—

3005 "Hospital-based physician", a pathologist, anesthesiologist, radiologist or emergency room
3006 physician who practices exclusively within the inpatient or outpatient hospital setting and who
3007 provides health care services to a carrier's insured only as a result of the insured being directed
3008 to the hospital inpatient or outpatient setting. This definition may be expanded, after consultation
3009 with a statewide advisory committee composed of an equal number of organizations representing
3010 providers and those representing health plans including but not limited to a representative from
3011 the Massachusetts Medical Society, the Massachusetts Hospital Association, the Massachusetts
3012 Association of Health Plans, the Massachusetts Association of Medical Staff Services, and Blue
3013 Cross Blue Shield of Massachusetts, by regulation to include additional categories of physicians
3014 who practice exclusively within the inpatient or outpatient hospital setting and who provide
3015 health care services to a carrier's insured only as a result of the insured being directed to the
3016 hospital inpatient or outpatient setting.

3017 SECTION 95. Section 1 of chapter 176O of the General Laws, as so appearing, is hereby further
3018 amended in lines 126 to 128 by striking out the definition of "Office of patient protection" and
3019 inserting in place thereof the following:—

3020 "Office of patient protection", the office in the division of health care cost and quality
3021 established by section 65 of chapter 118G, responsible for the administration and enforcement of
3022 sections 13, 14, 15 and 16.

3023 SECTION 96. Section 2 of chapter 176O of the General Laws, as so appearing, is hereby
3024 amended by striking out subsection (c) and inserting in place thereof the following subsection:—

3025 (c) Regulations promulgated by the bureau shall be consistent with and not duplicate or overlap
3026 with the regulations promulgated by the office of patient protection in the division of health care
3027 cost and quality established by section 65 of chapter 118G.

3028 SECTION 97. Chapter 176O of the General Laws is hereby amended by inserting after section 2
3029 the following 2 new sections:—

3030 Section 2A. (a) The bureau shall adopt a common application for initial credentialing or
3031 appointment and a common application for re-credentialing or reappointment. The bureau, after
3032 consultation with a statewide advisory committee composed of an equal number of organizations
3033 representing providers and those representing health plans including but not limited to a
3034 representative from the Massachusetts Medical Society, the Massachusetts Hospital Association,
3035 the Massachusetts Association of Health Plans, the Massachusetts Association of Medical Staff
3036 Services, and Blue Cross Blue Shield of Massachusetts, a representative of the board of
3037 registration in medicine, a representative of the board of registration in nursing and a
3038 representative of the department of public health, shall adopt and make any revisions to the

3039 common credentialing application forms that includes but is not limited to applicable
3040 accreditation as well as federal and state regulatory changes that will impact such forms. Such
3041 forms shall not be applicable in those instances where the carrier has both delegated
3042 credentialing to a provider organization and does not require submission of a credentialing
3043 application.

3044 (b) A carrier and a participating provider shall not use any initial physician credentialing
3045 application form other than the uniform initial physician application form or a uniform electronic
3046 version of said form. A carrier and a participating provider shall not use any physician re-
3047 credentialing application form other than the uniform physician re-credentialing application form
3048 or a uniform electronic version of said form. A carrier may require that a physician profile be
3049 submitted in addition to the uniform physician re-credentialing application form.

3050 (c) A carrier shall act upon and complete the credentialing process for 95 percent of complete
3051 initial physician credentialing applications submitted by or on behalf of a physician applicant
3052 within 30 calendar days of receipt of a complete application. An application shall be considered
3053 complete if it contains all of the following elements submitted by the physician applicant or
3054 designee or obtained by the carrier from a credentials verification organization certified by the
3055 National Committee for Quality Assurance: —

3056 (i) the application form is signed and appropriately dated by the physician applicant;

3057 (ii) all information on the application is submitted in a legible and complete manner and
3058 any affirmative answers are accompanied by explanations satisfactory to the carrier;

3059 (iii) a current curriculum vitae with appropriate required dates;

3060 (iv) a signed, currently dated Applicant's Authorization to Release Information form;

3061 (v) copies of the applicant's current licenses in all states in which the physician practices;

3062 (vi) a copy of the applicant's current Massachusetts controlled substances registration and a
3063 copy of the applicant's current federal DEA controlled substance certificate or, if not available, a
3064 letter describing prescribing arrangements;

3065 (vii) a copy of the applicant's current malpractice face sheet coverage statement including
3066 amounts and dates of coverage;

3067 (viii) hospital letter or verification of hospital privileges or alternate pathways;

3068 (ix) documentation of board certification or alternate pathways;

3069 (x) documentation of training, if not board certified;

3070 (xi) there are no affirmative responses on questions related to quality or clinical competence;

3071 (xii) there are no modifications to the Applicant's Authorization to Release Information Form;

3072 (xiii) there are no discrepancies between the information submitted by or on behalf of the
3073 physician and information received from other sources; and

3074 (xiv) the appropriate health plan participation agreement, if applicable.

3075 (d) A carrier shall report to a physician applicant or designee the status of a submitted initial
3076 credentialing application within a reasonable timeframe. Said report shall include, but not be
3077 limited to, the application receipt date and, if incomplete, an itemization of all missing or

3078 incomplete items. A carrier may return an incomplete application to the submitter. A physician

3079 applicant or designee shall be responsible for any and all missing or incomplete items.

3080 (e) A carrier shall notify a physician applicant of the carrier's credentialing committee's decision

3081 on an initial credentialing application within four business days of the decision. Said notice shall

3082 include the committee's decision and the decision date.

3083 (f) A physician, other than a primary care provider compensated on a capitated basis, who has

3084 been credentialed pursuant to the terms of this section shall be allowed to treat a carrier's

3085 insureds and shall be reimbursed by the carrier for covered services provided to a carrier's

3086 insureds effective as of the carrier's credentialing committee's decision date. A primary care

3087 physician compensated on a capitated basis who has been credentialed pursuant to the terms

3088 established in this section shall be allowed to treat a carrier's insureds and shall be reimbursed by

3089 the carrier for covered services provided to the carrier's insureds effective no later than the first

3090 day of the month following the carrier's credentialing committee's decision date.

3091 (g) This section shall not apply to the credentialing and re-credentialing by carriers of

3092 psychiatrists or hospital-based physicians.

3093 Section 2B. (a) The bureau's accreditation requirements related to credentialing and re-

3094 credentialing shall not require a carrier to complete the credentialing or re-credentialing process

3095 for hospital-based physicians.

3096 (b) Except as provided in paragraph (d), a carrier shall not require a hospital-based physician to

3097 complete the credentialing and re-credentialing process established pursuant to the bureau's

3098 accreditation requirements.

3099 (c) A carrier may establish an abbreviated data submission process for hospital-based
3100 physicians. Except as provided in paragraph (d) of this section, said process shall be limited to a
3101 review of the data elements required to be collected and reviewed pursuant to applicable federal
3102 and state regulations as well as national accreditation organization standards.

3103 (d) In the event that the carrier determines that there is a need to further review a hospital-based
3104 physician's credentials due to quality of care concerns, complaints from insureds, applicable law
3105 or other good faith concerns, the carrier may conduct such review as is necessary to make a
3106 credentialing or re-credentialing decision.

3107 (e) Nothing in this section shall be construed to prohibit a carrier from requiring a physician to
3108 submit information or taking other actions necessary for the carrier to comply with the applicable
3109 regulations of the board of registration in medicine.

3110 (f) The bureau, after consultation with a statewide advisory committee composed of an equal
3111 number of organizations representing providers and those representing health plans including but
3112 not limited to a representative from the Massachusetts Hospital Association, the Massachusetts
3113 Medical Society, the Massachusetts Association of Health Plans, the Massachusetts Association
3114 of Medical Staff Services, and Blue Cross and Blue Shield of Massachusetts, a representative of
3115 the board of registration in medicine, a representative of the board of registration in nursing and
3116 a representative of the department of public health, shall develop standard criteria and oversight
3117 guidelines that may be used by carriers to delegate the credentialing function to providers. Such
3118 criteria and oversight guidelines shall meet applicable accreditation standards.

3119 SECTION 98. Section 6 of chapter 176O, as so appearing, is hereby amended by striking clause
3120 (3) of subsection (a) and inserting in place thereof the following subsection:—

3121 (3) the limitations on the scope of health care services and any other benefits to be provided,

3122 including (i) all restrictions relating to preexisting condition exclusions, and (ii) an explanation

3123 of any facility fee, allowed amount, co-insurance, copayment, deductible, or other amount, that

3124 the insured may be responsible to pay to obtain covered benefits from network or out-of-network

3125 providers.

3126 SECTION 99. Section 6 of chapter 176O of the General Laws, as so appearing, is hereby further

3127 amended by striking out, in lines 52 to 54 paragraph (13) and inserting in place thereof the

3128 following paragraph:—

3129 (13) a statement on how to obtain the report regarding grievances from the office of patient

3130 protection pursuant to paragraph (2) of subsection (a) of section 65 of chapter 118G;

3131 SECTION 100. Section 9A of chapter 176O of the General Laws, as so appearing, is hereby

3132 amended by inserting after subsection (c), the following 2 subsections:—

3133 (d) limits the ability of either the carrier or the health care provider from disclosing the allowed

3134 amount and fees of services to an insured or insured's treating health care provider.

3135 (e) limits the ability of either the carrier or the health care provider from disclosing out-of-pocket

3136 costs to an insured.

3137 SECTION 101. Section 14 of chapter 176O of the General Laws, as so appearing, is hereby

3138 amended by striking out, in line 6 the words "section 217 of chapter 111" and inserting in place

3139 thereof the following:—section 65 of chapter 118G

3140 SECTION 102. Chapter 176O of the General Laws is hereby amended by striking out section 15,

3141 as so appearing, and inserting in place thereof the following section:—

3142 Section 15. (a) A carrier that allows or requires the designation of a primary care provider shall
3143 notify an insured at least 30 days before the disenrollment of such insured's primary care
3144 provider and shall permit such insured to continue to be covered for health services, consistent
3145 with the terms of the evidence of coverage, by such primary care provider for at least 30 days
3146 after said provider is disenrolled, other than disenrollment for quality-related reasons or for
3147 fraud. Such notice shall also include a description of the procedure for choosing an alternative
3148 primary care provider.

3149 (b) A carrier shall allow any female insured who is in her second or third trimester of pregnancy
3150 and whose provider in connection with her pregnancy is involuntarily disenrolled, other than
3151 disenrollment for quality-related reasons or for fraud, to continue treatment with said provider,
3152 consistent with the terms of the evidence of coverage, for the period up to and including the
3153 insured's first postpartum visit.

3154 (c) A carrier shall allow any insured who is terminally ill and whose provider in connection with
3155 said illness is involuntarily disenrolled, other than disenrollment for quality-related reasons or for
3156 fraud, to continue treatment with said provider, consistent with the terms of the evidence of
3157 coverage, until the insured's death.

3158 (d) A carrier shall provide coverage for health services for up to 30 days from the effective date
3159 of coverage to a new insured by a physician who is not a participating provider in the carrier's
3160 network if: (1) the insured's employer only offers the insured a choice of carriers in which said
3161 physician is not a participating provider, and (2) said physician is providing the insured with an
3162 ongoing course of treatment or is the insured's primary care provider. With respect to an insured
3163 in her second or third trimester of pregnancy, this provision shall apply to services rendered

3164 through the first postpartum visit. With respect to an insured with a terminal illness, this
3165 provision shall apply to services rendered until death.

3166 (e) A carrier may condition coverage of continued treatment by a provider under subsections (a)
3167 to (d), inclusive, upon the provider's agreeing (1) to accept reimbursement from the carrier at the
3168 rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing
3169 with respect to the insured in an amount that would exceed the cost sharing that could have been
3170 imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards
3171 of the carrier and to provide the carrier with necessary medical information related to the care
3172 provided; and (3) to adhere to such carrier's policies and procedures, including procedures
3173 regarding referrals, obtaining prior authorization and providing services pursuant to a treatment
3174 plan, if any, approved by the carrier. Nothing in this subsection shall be construed to require the
3175 coverage of benefits that would not have been covered if the provider involved remained a
3176 participating provider.

3177 (f) A carrier that requires an insured to designate a primary care provider shall allow such a
3178 primary care provider to authorize a standing referral for specialty health care provided by a
3179 health care provider participating in such carrier's network when (1) the primary care provider
3180 determines that such referrals are appropriate, (2) the provider of specialty health care agrees to a
3181 treatment plan for the insured and provides the primary care provider with all necessary clinical
3182 and administrative information on a regular basis, and (3) the health care services to be provided
3183 are consistent with the terms of the evidence of coverage. Nothing in this section shall be
3184 construed to permit a provider of specialty health care who is the subject of a referral to
3185 authorize any further referral of an insured to any other provider without the approval of the
3186 insured's carrier.

3187 (g) No carrier shall require an insured to obtain a referral or prior authorization from a primary
3188 care provider for the following specialty care provided by an obstetrician, gynecologist, certified
3189 nurse-midwife or family practitioner participating in such carrier's health care provider network:
3190 (1) annual preventive gynecologic health examinations, including any subsequent obstetric or
3191 gynecological services determined by such obstetrician, gynecologist, certified nurse-midwife or
3192 family practitioner to be medically necessary as a result of such examination; (2) maternity care;
3193 and (3) medically necessary evaluations and resultant health care services for acute or emergency
3194 gynecological conditions. No carrier shall require higher copayments, coinsurance, deductibles
3195 or additional cost sharing arrangements for such services provided to such insureds in the
3196 absence of a referral from a primary care provider. Carriers may establish reasonable
3197 requirements for participating obstetricians, gynecologists, certified nurse-midwives or family
3198 practitioners to communicate with an insured's primary care provider regarding the insured's
3199 condition, treatment, and need for follow-up care. Nothing in this section shall be construed to
3200 permit an obstetrician, gynecologist, certified nurse-midwife or family practitioner to authorize
3201 any further referral of an insured to any other provider without the approval of the insured's
3202 carrier.

3203 (h) A carrier shall provide coverage of pediatric specialty care, including mental health care, by
3204 persons with recognized expertise in specialty pediatrics to insureds requiring such services.

3205 (i) A carrier, including a dental or vision carrier, shall provide health, dental or vision care
3206 providers applying to be participating providers who are denied such status with a written reason
3207 or reasons for denial of such application.

3208 (j) No carrier shall make a contract with a health care provider which includes a provision
3209 permitting termination without cause. A carrier shall provide a written statement to a provider of
3210 the reason or reasons for such provider's involuntary disenrollment.

3211 (k) A carrier, including a dental or vision carrier, shall provide insureds, upon request, interpreter
3212 and translation services related to administrative procedures.

3213 SECTION 103. Section 20 of chapter 176O of the General Laws, as so appearing, is hereby
3214 amended in lines 26 to 30 by striking out paragraph (iv)(3) and inserting in place thereof the
3215 following paragraph:—

3216 (3) a statement that the office of patient protection, established by section 65 of chapter 118G, is
3217 available to assist consumers, a description of the grievance and review processes available to
3218 consumers under chapter 176O, and relevant contact information to access the office and these
3219 processes.

3220 SECTION 104. Chapter 176Q of the General Laws, as so appearing, is hereby amended by
3221 adding the following section:—

3222 Section 17. (a) The authority shall, upon verification of the provision of services and costs to a
3223 state-funded employee, assess a free rider surcharge on the non-providing employer under
3224 regulations promulgated by the authority.

3225 (b) The amount of the free rider surcharge on non-providing employers shall be determined by
3226 the authority under regulations promulgated by the authority, and assessed by the authority not
3227 later than 3 months after the end of each hospital fiscal year, with payment by non-providing
3228 employers not later than 180 days after the assessment. The amount charged by the authority

3229 shall be greater than 10 per cent but no greater than 100 per cent of the cost to the state of the
3230 services provided to the state-funded employee, considering all payments received by the state
3231 from other financing sources for free care; provided that the “cost to the state” for services
3232 provided to any state-funded employee may be determined by the authority as a percentage of
3233 the state’s share of aggregate costs for health services. The free rider surcharge shall only be
3234 triggered upon incurring $50,000 or more, in any hospital fiscal year, in free care services for
3235 any employer’s employees, or dependents of such persons, in aggregate, regardless of how many
3236 state-funded employees are employed by that employer.

3237 (c) The formula for assessing free rider surcharges on non-providing employers shall be set forth
3238 in regulations promulgated by the authority that shall be based on factors including, but not
3239 limited to: (i) the number of incidents during the past year in which employees of the non-
3240 providing employer received services reimbursed by the health safety net office under section
3241 39; (ii) the number of persons employed by the non-providing employer; (iii) the proportion of
3242 employees for whom the non-providing employer provides health insurance.

3243 (d) If a state-funded employee is employed by more than one non-providing employer at the time
3244 he or she receives services, the authority shall assess a free rider surcharge on each said
3245 employer consistent with the formula established by the authority under this section.

3246 (e) The authority shall specify by regulation appropriate mechanisms for implementing free rider
3247 surcharges on non-providing employers. Said regulations shall include, but not be limited to, the
3248 following provisions:—

3249 (i) Appropriate mechanisms that provide for determination and payment of surcharge by a non-
3250 providing employer including requirements for data to be submitted by employers, employees,
3251 acute hospitals and ambulatory surgical centers, and other persons; and

3252 (ii) Penalties for nonpayment or late payment by the non-providing employer, including
3253 assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of
3254 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.

3255 (f) All surcharge payments made under this section shall be deposited into the Commonwealth
3256 Care Trust Fund, established by section 2OOO of chapter 29.

3257 (g) A non-providing employer's liability to that fund shall in the case of a transfer of ownership
3258 be assumed by the successor in interest to the non-providing employer's.

3259 (h) If a non-providing employer fails to file any data, statistics or schedules or other information
3260 required under this chapter or by any regulation promulgated by the authority, the authority shall
3261 provide written notice of the required information. If the employer fails to provide information
3262 within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject to a civil
3263 penalty of not more than $5,000 for each week on which such violation occurs or continues,
3264 which penalty may be assessed in an action brought on behalf of the commonwealth in any court
3265 of competent jurisdiction.

3266 (i) The attorney general shall bring any appropriate action, including injunctive relief, as may be
3267 necessary for the enforcement of this chapter.

3268 (j) No employer shall discriminate against any employee on the basis of the employee's receipt
3269 of free care, the employee's reporting or disclosure of his employer's identity and other

3270 information about the employer, the employee’s completion of a Health Insurance Responsibility
3271 Disclosure form, or any facts or circumstances relating to “free rider” surcharges assessed
3272 against the employer in relation to the employee. Violation of this subsection shall constitute a
3273 per se violation of chapter 93A.

3274 (k) A hospital, surgical center, health center or other entity that provides uncompensated care
3275 pool services shall provide an uninsured patient with written notice of the criminal penalties for
3276 committing fraud in connection with the receipt of uncompensated care pool services. The
3277 authority shall promulgate a standard written notice form to be made available to health care
3278 providers in English and foreign languages. The form shall further include written notice of
3279 every employee’s protection from employment discrimination under this section.

3280 SECTION 105. The General Laws are hereby amended by inserting after chapter 176R the
3281 following chapter:-

3282 CHAPTER 176S

3283 CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

3284 Section 1. As used in this chapter, the following words shall have the following meanings unless
3285 the context clearly requires otherwise:

3286 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health insurance
3287 under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a
3288 nonprofit medical service corporation organized under chapter 176B; a health maintenance
3289 organization organized under chapter 176G; an organization entering into a preferred provider
3290 arrangement under chapter 176I; a contributory group general or blanket insurance for persons in

3291 the service of the commonwealth under chapter 32A; a contributory group general or blanket
3292 insurance for persons in the service of counties, cities, towns and districts, and their dependents
3293 under chapter 32B; the medical assistance program administered by the division of medical
3294 assistance pursuant to chapter 118E and in accordance with Title XIX of the Social Security Act
3295 or any successor statute; and any other medical assistance program operated by a governmental
3296 unit for persons categorically eligible for such program.

3297 "Commissioner", the commissioner of insurance.

3298 "Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.

3299 "Nondiscriminatory basis", a carrier shall be deemed to be providing coverage on a non-
3300 discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service
3301 limitation imposed on coverage for the care provided by a physician assistant which is less than
3302 any annual or lifetime dollar or unit of service limitation imposed on coverage for the same
3303 services by other participating providers.

3304 "Participating provider', a provider who, under terms and conditions of a contract with the
3305 carrier or with its contractor or subcontractor, has agreed to provide health care services to an
3306 insured with an expectation of receiving payment, other than coinsurance, co-payments or
3307 deductibles, directly or indirectly from the carrier.

3308 "Physician assistant", a person who is a graduate of an approved program for the training of
3309 physician assistants who is supervised by a registered physician in accordance with sections 9C
3310 to 9H, inclusive, of chapter 112, and who has passed the Physician Assistant National Certifying
3311 Exam or its equivalent.

3312 “Primary care provider”, a health care professional qualified to provide general medical care for
3313 common health care problems who (1) supervises, coordinates, prescribes, or otherwise provides
3314 or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains
3315 continuity of care within the scope of practice.

3316 Section 2. The commissioner and the group insurance commission shall require that all carriers
3317 recognize physician assistants as participating providers subject to section 3 and shall include
3318 coverage on a nondiscriminatory basis to their insureds for care provided by physician assistants
3319 for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include
3320 benefits for primary care, intermediate care and inpatient care, including care provided in a
3321 hospital, clinic, professional office, home care setting, long-term care setting, mental health or
3322 substance abuse program, or any other setting when rendered by a physician assistant who is a
3323 participating provider and is practicing within the scope of his professional authority as defined
3324 by statute, rule and physician delegation to the extent that such policy or contract currently
3325 provides benefits for identical services rendered by a provider of health care licensed by the
3326 commonwealth.

3327 Section 3. A participating provider physician assistant practicing within the scope of his license
3328 including all regulations requiring collaboration with or supervision by a physician under section
3329 9E of chapter 112, shall be considered qualified within the carrier’s definition of primary care
3330 provider to an insured.

3331 Section 4. Notwithstanding any general or special law to the contrary, a carrier that requires the
3332 designation of a primary care provider shall provide its insured with an opportunity to select a
3333 participating provider physician assistant as a primary care provider.

3334 Section 5. Notwithstanding any general or special law to the contrary, a carrier shall ensure that
3335 all participating provider physician assistants are included on any publicly accessible list of
3336 participating providers for the carrier.

3337 Section 6. A complaint for noncompliance against a carrier shall be filed with and investigated
3338 by the commissioner or the group insurance commission, whichever shall have regulatory
3339 authority over the carrier. The commissioner and the group insurance commission shall
3340 promulgate regulations to enforce this chapter.

3341 SECTION 106. Section 60K of chapter 231 of the general laws as so appearing is hereby
3342 amended in line 14 by striking the number "4" and inserting in place thereof the following
3343 number:—2

3344 SECTION 107. Section 85K of chapter 231 of the General Laws, as so appearing, is hereby
3345 amended by inserting after the word "costs" in line 8 with the following:—

3346 ; provided, however, in the context of medical malpractice claims against a non-profit charity
3347 providing health care, such cause of action shall not exceed the sum of $100,000, exclusive of
3348 interest and costs.

3349 SECTION 108. Chapter 231 of the General Laws is hereby amended by inserting after section
3350 60K the following 3 sections:—

3351 Section 60L. (a) Except as provided in this section a person shall not commence an action
3352 against a provider of health care as defined in the seventh paragraph of section 60B unless the
3353 person has given the health care provider written notice under this section of not less than 182
3354 days before the action is commenced.

3355 (b) The notice of intent to file a claim required under subsection (a) shall be mailed to the last

3356 known professional business address or residential address of the health care provider who is the

3357 subject of the claim.

3358 (c) The 182 day notice period in subsection (a) is shortened to 91 days if either of the following

3359 conditions exists:

3360 (1) the claimant has previously filed the 182 day notice required against another health care

3361 provider involved in the claim; and

3362 (2) the claimant has filed a complaint and commenced an action alleging medical malpractice

3363 against one or more of the health care providers involved in the claim.

3364 (d) The 182 day notice of intent described in subsection (a) is not required if the claimant did

3365 not identify and could not reasonably have identified a health care provider to which notice must

3366 be sent as a potential party to the action before filing the complaint.

3367 (e) The notice given to a health care provider under this section shall contain a statement of at

3368 least all of the following:

3369 (1) the factual basis for the claim;

3370 (2) the applicable standard of care alleged by the claimant;

3371 (3) the manner in which it is claimed that the applicable standard of care was breached by the

3372 health care provider;

3373 (4) the alleged action that should have been taken to achieve compliance with the alleged

3374 standard of care;

3375 (5) the manner in which it is alleged the breach of the standard of care was a proximate cause of
3376 the injury claimed in the notice; and

3377 (6) the names of all health care providers the claimant is notifying under this section in relation
3378 to the claim.

3379 (f) 56 days after giving notice under this section, the claimant shall allow the health care
3380 provider receiving the notice access to all of the medical records related to the claim that are in
3381 the claimant's control, and shall furnish release for any medical records related to the claim that
3382 are not in the claimant's control, but of which the claimant has knowledge. This subsection does
3383 not restrict a patient's right of access to his or her medical records under any other provision of
3384 law.

3385 (g) Within 150 days after receipt of notice under this section, the health care provider or
3386 authorized representative against whom the claim is made shall furnish to the claimant or his or
3387 her authorized representative a written response that contains a statement including the
3388 following:

3389 (1) the factual basis for the defense, if any, to the claim;

3390 (2) the standard of care that the health care provider claims to be applicable to the action;

3391 (3) the manner in which it is claimed by the health care provider that there was or was not
3392 compliance with the applicable standard of care; and

3393 (4) the manner in which the health care provider contends that the alleged negligence of the
3394 health care provider was or was not a proximate cause of the claimant's alleged injury or alleged
3395 damage.

3396 (h) If the claimant does not receive the written response required under subsection (g) within the
3397 required 150 day time period, the claimant may commence an action alleging medical
3398 malpractice upon the expiration of the 150 day period. Further, if a provider fails to respond
3399 within 150 days and that fact is made known to the Court in the plaintiffs' complaint or by any
3400 other means then interest on any judgment against that provider will accrue and be calculated
3401 from the date that the notice was filed rather than the date that suit is filed. At any time before
3402 the expiration of the 150 day period, the claimant and the provider may agree to an extension of
3403 the 150 day period.

3404 (i) If at any time during the applicable notice period under this section a health care provider
3405 receiving notice under this section informs the claimant in writing that the health care provider
3406 does not intend to settle the claim within the applicable notice period, the claimant may
3407 commence an action alleging medical malpractice against the health care provider, so long as the
3408 claim is not barred by the statute of limitations or repose.

3409 (j) As to any lawsuit against any health care provider(s) filed within six months of the statute of
3410 limitations expiring as to any claimant, or within one year of the statute of repose expiring as to
3411 any claimant, compliance with this section (MGL ch. 231, sec 60L) is not required.

3412 (k) Nothing in this act shall prohibit the filing of suit at any time in order to seek court orders to
3413 preserve and permit inspection of tangible evidence.

3414 Section 60M. In any action for malpractice, negligence, error, omission, mistake or the
3415 unauthorized rendering of professional services against a provider of health licensed pursuant to
3416 section 2 of chapter 112, including actions pursuant to section 60B of this chapter, an expert

3417 witness shall have been engaged in the practice of medicine at the time of the alleged
3418 wrongdoing.

3419 Section 60N. In any action for malpractice, negligence, error, omission, mistake or the
3420 unauthorized rendering of professional services against a provider of health licensed pursuant to
3421 section 2 of chapter 112, including actions pursuant to section 60B of this chapter, an expert
3422 witness shall be board certified in the same specialty as the defendant physician as licensed
3423 pursuant to section 2 of chapter 112.

3424 SECTION 109. Chapter 233 of the General Laws is hereby amended by inserting after section
3425 79K the following section:-

3426 Section 79L. (a) As used in this section the following terms shall have the following meaning:

3427 "Health Care Provider", means any of the following heath care professionals licensed pursuant to
3428 chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist,
3429 optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social
3430 worker, speech-language pathologist, audiologist, marriage and family therapist and a mental
3431 health counselor. The term shall also include any corporation, professional corporation,
3432 partnership, limited liability company, limited liability partnership, authority, or other entity
3433 comprised of such health care providers.

3434 "Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health
3435 agency. The term shall also include any corporation, professional corporation, partnership,
3436 limited liability company, limited liability partnership, authority, or other entity comprised of
3437 such facilities.

3438 “Unanticipated outcome” means the outcome of a medical treatment or procedure, whether or
3439 not resulting from an intentional act, that differs from an intended result of such medical
3440 treatment or procedure.

3441 (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly
3442 experiencing an unanticipated outcome of medical care, any and all statements, affirmations,
3443 gestures, activities or conduct expressing benevolence, regret, apology, sympathy,
3444 commiseration, condolence, compassion, mistake, error, or a general sense of concern which are
3445 made by a health care provider, facility or an employee or agent of a health care provider or
3446 facility, to the patient, a relative of the patient, or a representative of the patient and which relate
3447 to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative
3448 proceeding, unless the maker of the statement or a defense expert witness, when questioned
3449 under oath during the litigation about facts and opinions regarding any mistakes or errors that
3450 occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in
3451 which case the statements and opinions made about the mistake or error are admissible for all
3452 purposes. In situations where a patient suffers an unanticipated outcome with significant medical
3453 complication(s) resulting from the provider’s mistake, the health care provider, facility, or an
3454 employee or agent of a health care provider or facility shall fully inform the patient, and when
3455 appropriate the patient's family, about said unanticipated outcome.

3456 SECTION 110. Section 4 of Chapter 260 of the Generals is hereby amended at the end of the
3457 2nd paragraph in line 28 after the word “body.” by adding the following:—

3458 The statutes of limitation and repose in this paragraph shall be tolled for a period of 180 days

3459 when a notice of intent to file a claim, pursuant to section 60L(a) of chapter 231, is sent to a

3460 provider of health care as defined in the seventh paragraph of section 60B of chapter 231.

3461 SECTION 111. Section 1 of chapter 205 of the acts of 2007 is hereby repealed.

3462 SECTION 112. Section 3 of chapter 305 of the acts of 2008 is hereby repealed.

3463 SECTION 113. Section 4 of chapter 305 of the acts of 2008 is hereby repealed.

3464 SECTION 114. Sections 15 and 58 of chapter 305 of the acts of 2008 are hereby repealed.

3465 SECTION 115. Sections 2 and 3 of chapter 288 of the acts of 2010 are hereby repealed.

3466 SECTION 116. Section 54 of chapter 288 of the Acts of 2010 is hereby repealed.

3467 SECTION 117. Nothing in this act shall be construed to preclude an individual from obtaining

3468 additional insurance or paying out of pocket for any medical service not covered by the

3469 individual's health plan, provided, however, that supplemental insurance may not cover

3470 copayments, deductibles, co-insurance or other patient payment responsibility for services that

3471 are included in the individual's health plan.

3472 SECTION 118. To promote the adoption of alternative payment methodologies and contracting

3473 with ACOs by both private and public purchasers of health care, the division shall, by August 15,

3474 2012, request from the federal office of the inspector general the following:

3475 (i) a waiver of the provisions of, or expansion of the "safe harbors" to, 42 U.S.C. section 1320a-

3476 7b and implementing regulations or any other necessary authorization the division determines

3477 may be necessary to permit certain shared risk and other risk sharing arrangements among
3478 providers and ACOs; and

3479 (ii) a waiver of or exemption from the provisions of 42 U.S.C. section 1395nn(a) to (e) and
3480 implementing regulations or other necessary authorization the division determines may be
3481 necessary to permit physician referrals to other providers as needed to support the transition to
3482 and implementation of global and alternative payment systems and formation of ACOs.

3483 SECTION 119. Notwithstanding any general or special law, rule or regulation to the contrary,
3484 the commissioner of insurance shall promulgate regulations requiring any carrier, as defined in
3485 Chapter 176O of the general laws, and their contractors to effectively comply with and
3486 implement the federal Mental Health Parity and Addiction Equity Act of 2008, Section 511 of
3487 Public Law 110-343. The commissioner of insurance shall promulgate said regulations not later
3488 than 90 days after the effective date of this act. Said regulations shall be implemented as part of
3489 any provider contracts and any carrier's health benefit plans which are delivered, issued, entered
3490 into, renewed, or amended on or after this act's effective date.

3491 Starting on July 1, 2013, the commissioner of insurance shall require all carriers, as so defined,
3492 and their contractors, to submit an annual report to the Division of Insurance, which shall be a
3493 public record, certifying and outlining how their health benefit plans are in compliance with the
3494 federal Mental Health Parity Act and the provisions of this section. The division of insurance
3495 shall forward all such reports to the office of the attorney general for verification of compliance
3496 with the federal Mental Health Parity Act.

3497 SECTION 120. Notwithstanding any general or special law, rule or regulation to the contrary,
3498 the office of Medicaid shall promulgate regulations requiring any Medicaid health plan and

3499 managed care organization and their health plans and any behavioral health management firm
3500 and third party administrator under contract with a Medicaid managed care organization to
3501 effectively comply with and implement the federal Mental Health Parity and Addiction Equity
3502 Act of 2008, Section 511 of Public Law 110-343. The office of Medicaid shall promulgate said
3503 regulations not later than 90 days after the effective date of this act. Said regulations shall be
3504 implemented as part of any provider contracts and any carrier's health benefit plans which are
3505 delivered, issued, entered into, renewed, or amended on or after this act's effective date.

3506 Starting on July 1, 2013, the Office of Medicaid shall submit an annual report to the co-chairs of
3507 the Joint Committee on Health Care Financing, the co-chairs of the Joint Committee on Mental
3508 Health and Substance Abuse, the clerk of the Senate, and the clerk of the House of
3509 Representatives certifying and outlining how the health benefit plans under the Office of
3510 Medicaid, and any contractors, are in compliance with the federal Mental Health Parity Act and
3511 the provisions of this section. The office of Medicaid shall forward all such reports to the office
3512 of the attorney general for verification of compliance with the federal Mental Health Parity Act.

3513 SECTION 121. Notwithstanding any law or regulation to the contrary, the group insurance
3514 commission, office of Medicaid, and the commonwealth connector authority may offer smart
3515 tiered plans, as defined in section 11 of chapter 176J, on January 1, 2014.

3516 SECTION 122. (a) Notwithstanding any general or special law to the contrary, this section shall
3517 facilitate the orderly transfer of the employees, proceedings, rules and regulations, property and
3518 legal obligations of the following functions of state government from the transferor agencies to
3519 the transferee agency, defined as follows: the functions of the health information technology
3520 council and the Massachusetts eHealth Institute, established under section 6D of chapter 40J, as

3521 the transferor agencies, to the division of health care cost and quality established under section 2
3522 of chapter 118G, as the transferee agency.

3523 (b) The employees of the transferor agencies, including those who were appointed immediately
3524 before the effective date of this act and who hold permanent appointment in positions classified
3525 under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A
3526 of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are
3527 hereby transferred to the transferee agency, without interruption of service within the meaning of
3528 said section 9A of said chapter 31, without impairment of seniority, retirement or other rights of
3529 the employee, and without reduction in compensation or salary grade, notwithstanding any
3530 change in title or duties resulting from such reorganization, and without loss of accrued rights to
3531 holidays, sick leave, vacation and benefits, and without change in union representation or
3532 certified collective bargaining unit as certified by the state department of labor relations or in
3533 local union representation or affiliation. Any collective bargaining agreement in effect
3534 immediately before the transfer date shall continue in effect and the terms and conditions of
3535 employment therein shall continue as if the employees had not been so transferred. The
3536 reorganization shall not impair the civil service status of any such reassigned employee who
3537 immediately before the effective date of this act either holds a permanent appointment in a
3538 position classified under chapter 31 of the General Laws or has tenure in a position by reason of
3539 section 9A of chapter 30 of the General Laws. Notwithstanding any other general or special law
3540 to the contrary, all such employees shall continue to retain their right to collectively bargain
3541 pursuant to chapter 150E of the General Laws and shall be considered employees for the
3542 purposes of said chapter 150E. Nothing in this section shall be construed to confer upon any
3543 employee any right not held immediately before the date of said transfer, or to prohibit any

3544 reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or abolition of
3545 position not prohibited before such date.

3546 (c) All petitions, requests, investigations and other proceedings appropriately and duly brought
3547 before the transferor agencies or duly begun by the transferor agencies and pending before it
3548 before the effective date of this act, shall continue unabated and remain in force, but shall be
3549 assumed and completed by the transferee agency.

3550 (d) All orders, rules and regulations duly made and all approvals duly granted by the transferor
3551 agency, which are in force immediately before the effective date of this act, shall continue in
3552 force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in
3553 accordance with law, by the transferee agency.

3554 (e) All books, papers, records, documents, equipment, buildings, facilities, funds, accounts, cash
3555 and other property, both personal and real, including all such property held in trust, which
3556 immediately before the effective date of this act are in the custody of the transferor agencies shall
3557 be transferred to the transferee agency.

3558 (f) All duly existing contracts, leases and obligations of the transferor agencies shall continue in
3559 effect but shall be assumed by the transferee agency.

3560 (g) The comptroller shall be authorized to take any actions necessary to support the transfers
3561 outlined in this section. No existing right or remedy of any character shall be lost, impaired or
3562 affected by this act.

3563 SECTION 123. (a) Notwithstanding any general or special law to the contrary, this section shall
3564 facilitate the orderly transfer of the employees, proceedings, rules and regulations, property and

3565 legal obligations of the following functions of state government from the transferor agencies to
3566 the transferee agency, defined as follows: the functions of the division of health care finance and
3567 policy, as the transferor agency, to the division of health care cost and quality, as the transferee
3568 agency.

3569 (b) The employees of the transferor agencies, including those who were appointed immediately
3570 before the effective date of this act and who hold permanent appointment in positions classified
3571 under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A
3572 of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are
3573 hereby transferred to the transferee agency, without interruption of service within the meaning of
3574 said section 9A of said chapter 31, without impairment of seniority, retirement or other rights of
3575 the employee, and without reduction in compensation or salary grade, notwithstanding any
3576 change in title or duties resulting from such reorganization, and without loss of accrued rights to
3577 holidays, sick leave, vacation and benefits, and without change in union representation or
3578 certified collective bargaining unit as certified by the state department of labor relations or in
3579 local union representation or affiliation. Any collective bargaining agreement in effect
3580 immediately before the transfer date shall continue in effect and the terms and conditions of
3581 employment therein shall continue as if the employees had not been so transferred. The
3582 reorganization shall not impair the civil service status of any such reassigned employee who
3583 immediately before the effective date of this act either holds a permanent appointment in a
3584 position classified under chapter 31 of the General Laws or has tenure in a position by reason of
3585 section 9A of chapter 30 of the General Laws. Notwithstanding any other general or special law
3586 to the contrary, all such employees shall continue to retain their right to collectively bargain
3587 pursuant to chapter 150E of the General Laws and shall be considered employees for the

3588 purposes of said chapter 150E. Nothing in this section shall be construed to confer upon any
3589 employee any right not held immediately before the date of said transfer, or to prohibit any
3590 reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or abolition of
3591 position not prohibited before such date.

3592 (c) All petitions, requests, investigations and other proceedings appropriately and duly brought
3593 before the transferor agencies or duly begun by the transferor agencies and pending before it
3594 before the effective date of this act, shall continue unabated and remain in force, but shall be
3595 assumed and completed by the transferee agency.

3596 (d) All orders, rules and regulations duly made and all approvals duly granted by the transferor
3597 agency, which are in force immediately before the effective date of this act, shall continue in
3598 force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in
3599 accordance with law, by the transferee agency.

3600 (e) All books, papers, records, documents, equipment, buildings, facilities, funds, accounts, cash
3601 and other property, both personal and real, including all such property held in trust, which
3602 immediately before the effective date of this act are in the custody of the transferor agencies shall
3603 be transferred to the transferee agency.

3604 (f) All duly existing contracts, leases and obligations of the transferor agencies shall continue in
3605 effect but shall be assumed by the transferee agency.

3606 (g) The comptroller shall be authorized to take any actions necessary to support the transfers
3607 outlined in this section. No existing right or remedy of any character shall be lost, impaired or
3608 affected by this act.

3609 SECTION 124. Notwithstanding any general or special law to the contrary, the Secretary of
3610 Health and Human Services shall transfer any remaining funds from the Distressed Provider
3611 Expendable Trust Fund, established in Chapter 241 of the Acts of 2004, to the Distressed
3612 Hospital Trust Fund established in Section 2DDDD of chapter 29 of the General Laws..

3613 SECTION 125. There shall be on the books of the commonwealth, an Infrastructure
3614 Improvement Expendable Trust fund. The division shall have control over said trust fund. The
3615 fund shall retain 50% of its total funding for the purposes of improving the commonwealth's
3616 health care infrastructure needs. The other 50% of total funding shall be transferred to the
3617 Distressed Hospital Trust Fund, as created by section 2DDDD of chapter 29.

3618 SECTION 126. Notwithstanding any general or special law to the contrary, the division of
3619 health care cost and quality, established under chapter 118G, shall continue to collect all
3620 assessments formerly collected by the division of health care finance and policy, including,
3621 without limitation, health safety net assessments, nursing home user fees and child immunization
3622 assessments.

3623 SECTION 127. If any provision of this act or its application to any entity, person or
3624 circumstance is held invalid by a court of competent jurisdiction, the invalidity shall not affect
3625 other provisions or applications of this act that can be given effect without the invalid provision
3626 or application, and to this end the provisions of the act are severable.

3627 SECTION 128. Notwithstanding any general or special law to the contrary, all employees of the
3628 division of health care cost and quality established under chapter 118G shall qualify for
3629 participation in the state employees' retirement system established under the provisions of
3630 chapter 32 and state employees' contributory group insurance under chapter 32A.

3631 SECTION 129. Notwithstanding any law or regulation to the contrary, the division of insurance
3632 shall conduct a study on the adequacy of reserves for both payers and providers. The study shall
3633 include the following: (1) current reserves held by payers, (2) current reserves held by providers,
3634 (3) a formula to calculate the minimum necessary reserves for payors based on their levels of
3635 risk, (4) a formula to calculate the minimum necessary reserves for providers based on their
3636 levels of risk, and (5) a threshold of excess reserves. Minimum necessary reserves shall mean the
3637 amount of reserves required for a payer or provider to be fiscally solvent. The threshold of
3638 excess reserves shall represent an amount beyond what a payer or provider should reasonably
3639 hold above the necessary reserves amount. The level of risk shall mean the possible percentages
3640 of risk a provider or payer has in any risk sharing arrangement. Upon completion of this study,
3641 the division shall promulgate all necessary regulations to implement the findings of the study.

3642 The division shall then issue a report on its findings to the senate and house committees on ways
3643 and means and the joint committee on health care financing by July 1, 2013.

3644 SECTION 130. Section 27 of Chapter 141 of the Acts of 2000 is hereby amended by striking out
3645 the phrase “Health Insurance Consumer Protections” and inserting in place thereof the following
3646 phrase:- “Health Care Consumer Protections”.

3647 SECTION 131. Section 1 of Chapter 176O of the General Laws is hereby amended by inserting
3648 before the definition of “Adverse determination” the following definition:-

3649 “Accountable care organization”, an accountable care organization as defined in chapter 118J.

3650 SECTION 132. Section 1 of Chapter 176O of the General Laws is hereby amended by inserting
3651 after the definition of “Emergency medical condition” the following definition:-

3652 “Executive director”, the executive director of the division of health care cost and quality.

3653 SECTION 133. Section 1 of Chapter 176O of the General Laws is hereby amended by inserting
3654 after the definition of “Participating provider” the following definition:-

3655 “Patient centered medial home”, a patient centered medical home as defined in section 45 of
3656 118G.

3657 SECTION 134. Section 1 of Chapter 176O of the General Laws is hereby amended by inserting
3658 after the definition of “Prospective review” the following definition:-

3659 “Physician organization”, a physician organization as defined in section 53H of chapter 111.

3660 SECTION 135. Chapter 176O of the General Laws is hereby amended by inserting at the end
3661 thereof the following 2 sections:-

3662 Section 22. (a) Accountable care organizations, patient centered medical homes, or physician
3663 organizations who receive an alternative payment with shared risk shall create internal appeals
3664 processes. The processes shall be available to the public in both written and available by request
3665 in electronic format.

3666 (b) The internal appeals processes in subsection (a) shall be subject to the following
3667 requirements: (1) timing periods such as (A) internal appeals shall be completed in a period no
3668 longer than 14 days and (B) provided that an expedited internal appeal shall be completed in a
3669 period no longer that 3 days for a patient with a terminal illness; and (2) offer an external opinion
3670 unless it would be impractical for expedited internal appeals.

3671 (c) Accountable care organizations and patient centered medical homes with an approval from
3672 the executive director shall designate a third party as an ombudsman. Said ombudsman shall act

3673 as an advocate for patients. Provided that any patient who elects to have an independent care
3674 coordinator; said care coordinator may act as the patient advocate.

3675 (d) The executive director shall promulgate regulations necessary to implement this section.

3676 Section 23. (a) Accountable care organizations, patient centered medical homes, or physician
3677 organizations who receive a global payment shall provide an external second opinion. The
3678 external second opinion shall be conducted by a provider who is not a member of the global
3679 payment risk sharing arrangement.

3680 (b) The accountable care organization, patient centered medical home or physician organization
3681 shall be responsible for reimbursing the provider of the second opinion. Said provider shall
3682 receive a rate equal to the in-network contractual rate or if such rate does not exist, and then the
3683 parties shall contract for a rate.

3684 (c) If the provider of the second opinion determines that the denied of service is medically
3685 necessary, then the accountable care organization, patient centered medical home or physician
3686 organization shall provide such services until the office of patient protection rules otherwise.

3687 SECTION 136. Chapter 12 of the General Laws is hereby amended by inserting at the end
3688 thereof the following section:

3689 Section 33. (a) The Attorney General shall, pursuant to G.L. c. 93A, section 2(c), within 180
3690 days of the enactment of this section, investigate and issue regulations proscribing unfair,
3691 deceptive, or anticompetitive conduct within the Commonwealth's healthcare marketplace. Such
3692 regulations shall include, at a minimum, the prohibition of anticompetitive contracting practices
3693 between and/or among acute care hospitals and insurers, in which the acute care hospital

3694 possesses the market power to impose non-transitory increases in rates charged for health care
3695 services.

3696 (b) The following shall be unfair methods of competition and unfair or deceptive acts or
3697 practices for providers or provider organizations: (i) entering into any agreement to commit or
3698 by any concerted action committing any act of boycott, coercion, or intimidation resulting in or
3699 tending to result in unreasonable restraint of or monopoly in the delivery of health care services,
3700 contracting for payment for health care services, or the business of insurance; (ii) seeking to set
3701 the price to be paid by any carrier for network contracts at rates that are excessive, unreasonable,
3702 discriminatory, predatory, or would otherwise cause the carrier to violate the requirements of its
3703 licensure or accreditation; (iii) engaging in any unfair discrimination between individuals who
3704 are similarly covered by network contracts; and (iv) making, publishing, disseminating,
3705 circulating, or placing before the public, directly or indirectly, any assertion, representation or
3706 statement which is untrue, deceptive or misleading.

3707 SECTION 137. Chapter 118E of the General Laws is hereby amended by inserting after section
3708 9E the following section:-

3709 Section 9F. (a) As used in this section, the follow words shall have the following meanings:-

3710 "Dual eligible", or "dually eligible person", any person age 21 or older and under age 65 who is
3711 enrolled in both Medicare and either MassHealth or CommonHealth; provided that the executive
3712 office may include within the definition of dual eligible any person enrolled in MassHealth or
3713 CommonHealth who also receives benefits under Title II of the Social Security Act on the basis
3714 of disability and will be eligible for Medicare within 24 months, provided that the executive

3715 office may limit eligibility to those who will be eligible for Medicare within a prescribed number
3716 of months that is less than 24.

3717 "Integrated care organization" or "ICO", a comprehensive network of medical, health care and
3718 long term services and supports providers that integrates all components of care, either directly
3719 or through subcontracts and has been contracted with by the Executive Office of Health and
3720 Human Services and designated an ICO to provide services to dually eligible individuals
3721 pursuant to this section.

3722 (b) Members of the MassHealth dual eligible pilot program on ICOs or any successor program
3723 integrating care for dual eligible persons shall initially be provided an independent community
3724 care coordinator by the ICO or successor organization, who shall be a participant in the
3725 member's care team. The member may direct the withdrawal or reinstatement of the independent
3726 care coordinator at any time. The community care coordinator shall assist in the development of
3727 a long term support and services care plan. The community care coordinator shall:

3728 (1) participate in initial and ongoing assessments of the health and functional status of the
3729 member, including determining appropriateness for long term care support and services, either in
3730 the form of institutional or community-based care plans and related service packages necessary
3731 to improve or maintain enrollee health and functional status;

3732 (2) arrange and, with the agreement of the care team, coordinate and authorize the
3733 provision of appropriate institutional and community long term care and supports and services,
3734 including assistance with the activities of daily living and instrumental activities of daily living,
3735 housing, home-delivered meals, transportation, and under specific conditions or circumstances

3736 established by the ICO or successor organization, authorize a range and amount of community-

3737 based services; and

3738 (3) monitor the appropriate provision and functional outcomes of community long term

3739 care services, according to the service plan as deemed appropriate by the care team; and

3740 track member satisfaction and the appropriate provision and functional outcomes of community

3741 long term care services, according to the service plan as deemed appropriate by the care team.

3742 (c) The ICO or successor organization shall not have a direct or indirect financial ownership

3743 interest in an entity that serves as an independent care coordinator. Providers of institutional or

3744 community based long term services and supports on a compensated basis shall not function as

3745 an independent care coordinator, provided however that the secretary may grant a waiver of this

3746 restriction upon a finding that public necessity and convenience require such a waiver. In the

3747 case of a member in the program age 60 or older, the member shall be offered the option of the

3748 services of an independent care coordinator as designated by the executive office of elder affairs

3749 pursuant to the provisions of section 4B of chapter 19 A. For purposes of this section, an

3750 organization compensated to provide only evaluation, assessment, coordination and fiscal

3751 intermediary services shall not be considered a provider of long term services and supports.

3752 SECTION 138. Notwithstanding any law or rule the contrary, the health care workforce center

3753 shall investigate the possibility of dedicating funds for joint appointments for clinicians with

3754 clinical agencies and universities. As part of the arrangement, clinicians pursuing doctoral

3755 education would receive tuition and fee reimbursement for maintaining a clinical position and

3756 teaching at the entry level of the academic program while pursuing their doctoral degree.

3757 SECTION 139. Section 21 shall take effect on January 1, 2015.

3758 SECTION 140. Section 74 shall take effect on January 1, 2017.