SENATE . . . . . No. 2260

The Commonwealth of Massachusetts

SENATE, May 09, 2012

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

For the committee,

STEPHEN M. BREWER.

SENATE . . . . . No. 2260

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation.

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

SECTION 1. Section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 25, 29, 32, 35, 37, 39, 40, 44 and 45, 47, 48, 54, 86, 89 and 93, the word "division" and inserting in place thereof, in each instance, the following word:- institute.

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

SECTION 3. Section 105 of chapter 6 of the General Laws , as amended by section 9 of chapter 3 of the acts of 2011, is hereby further amended by striking out the words "commissioner of health care finance and policy" and inserting in place thereof the following words:- executive director of the institute of health care finance and policy.

SECTION 4. Section 16 of chapter 6A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 52, the words "pursuant to section 2A

of chapter 118G" and inserting in place thereof the following words:- under section 13C of chapter 118E.

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 Sections 16J to 16L, inclusive, of said chapter 6A of the General Laws are hereby repealed.

SECTION 6. Section 16M of said chapter 6A, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 3 and 4, the words "commissioner of health care financing" and inserting in place thereof the following words:- executive director of the institute of health care finance.

SECTION 7. Section 16M of said chapter 6A, as so appearing, is hereby further amended by striking out, in lines 23, 32, 39 and 43 the word "division" and inserting in place thereof, in each instance, the following word:- institute.

SECTION 8. Said section 16M of said chapter 6A, as so appearing, is hereby further amended by striking out, in line 24, the word "118G" and inserting in place thereof the following word:- 12C.

SECTION 9. Section 16N of said chapter 6A, as so appearing, is hereby amended by striking out, in lines 5 and 6, the words "commissioner of health care finance and policy" and inserting in place thereof the following words:- executive director of the institute of health care finance and policy.

SECTION 10. Subsection (a) of section 16O of said chapter 6A, as so appearing, is hereby amended by striking out the fifth sentence.

SECTION 11. The third sentence of subsection (c) of section 4R of chapter 7 of the General Laws, as inserted by section 15 of chapter 68 of the acts of 2011, is hereby amended by striking out the word “division” and inserting in place thereof the following word:- institute.

SECTION 12. Section 22N of said chapter 7, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 10 and 37, the word “118G” and inserting in place thereof, in each instance, the following word:- 118E.

SECTION 13. Chapter 12 of the General Laws is hereby amended by inserting after section 11M the following section:-

Section 11N. (a) The attorney general shall monitor trends in the health care market including, but not limited to, trends in provider organization size and composition, consolidation in the provider market, payer contracting trends and patient access and quality issues in the health care market.

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

(c) The attorney general shall provide assistance as needed to support efforts by the commonwealth to obtain exemptions or waivers from certain federal laws, to the extent the attorney general determines such exemptions or waivers are necessary, including, from the federal Office of the Inspector General, a waiver of, or expansion of, the “safe harbors” provided for under 42 U.S.C. section 1320a-7b and obtaining from the federal Office of the Inspector General a waiver of, or exemption from, 42 U.S.C. section 1395nn subsections (a) to (e).

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

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

Chapter 12C

Institute of Health Care Finance and Policy

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

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

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

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

"Alternative payment methodologies", methods of payment that are not fee-for-service reimbursements; provided that, "alternative payment methodologies" may include, but not be

limited to, global payments, shared savings arrangements, bundled payments and episodic payments.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“General health supplies, care or rehabilitative services and accommodations”, all supplies, care and services of medical, optometric, dental, surgical, podiatric, psychiatric, therapeutic, diagnostic, rehabilitative, supportive or geriatric nature, including inpatient and outpatient hospital care and services, and accommodations in hospitals, sanatoria, infirmaries,

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

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

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

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

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

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

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

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

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

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

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

"Institute", the institute of health care finance and policy.

"Major service category," a set of service categories to be established by regulation, which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii) outpatient and ambulatory services, by categories as defined by the Centers for Medicare and

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

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

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

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

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

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

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

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

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

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

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

“Provider organization,” any corporation, partnership, business trust, association or organized group of persons whether incorporated or not that consists of or represents 1 or more providers in contracting with carriers for the payments the provider or providers receive for the provision of heath care services; provided, that “provider organization” shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, provider networks, accountable care organizations and any other organization that contracts with carriers for payment for health care services.

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

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

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

"Registered provider organization," a provider organization that has been registered in accordance with this chapter and regulations promulgated under this chapter.

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

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

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

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

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

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

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

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

"Third party payer", an entity including, but not limited to, Title XVIII and Title XIX programs, other governmental payers, insurance companies, health maintenance organizations and nonprofit hospital service corporations. Third party payer shall not include a purchaser

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

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

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

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

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

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

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

Section 4. The executive director may appoint and remove, subject to appropriation, such agents and subordinate officers as the executive director may consider necessary and may establish such subdivisions within the institute as the executive director considers appropriate to fulfill the following duties: (i) to collect, analyze and disseminate health care data to assist in the formulation of health care policy and in the provision and purchase of health care services including, but not limited to, collecting, storing and maintaining data in a payer and provider claims database; (ii) to provide an analysis of health care spending trends as compared to the health care cost growth benchmark established by the health care quality and finance authority under section 5 of chapter 176S; (iii) to develop and administer a registration system for provider organizations and collect, analyze and disseminate information regarding provider organizations to increase the transparency and improve the functioning of the health care system; (iv) to provide information to, and work with, the general court and other state agencies including, but not limited to, the executive office of health and human services, the department of public health, the department of mental health, the health care quality and finance authority, the office of Medicaid and the division of insurance to collect and disseminate data concerning the cost, price and functioning of the health care system in the commonwealth and the health status of individuals; (v) to participate in and provide data and data analysis for annual hearings conducted by the health care quality and finance authority concerning health care provider and payer costs,

prices and cost trends; and (vi) report to consumers comparative health care cost and quality information through the consumer health information website established under section 20. The institute shall make available actual costs and prices of health care services, as supplied by each provider, to the general public in a conspicuous manner on the institute's official website.

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

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

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

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

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

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

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

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

The assessed amount for hospitals shall be not less than 33 per cent of the amount appropriated by the general court for the expenses of the institute minus amounts collected from (1) filing fees; (2) fees and charges generated by the institute's publication or dissemination of reports and information; and (3) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Each acute hospital shall pay such assessed amount multiplied by the ratio of the hospital's gross patient service revenues to the total of all such hospital's gross patient services revenues. Each acute hospital shall make a preliminary payment to the institute on October 1 of each year in an amount equal to ½ of the previous year's total assessment. Thereafter, each hospital shall pay, within 30 days notice from the institute, the balance of the total assessment for the current year based upon its most current projected gross patient service revenue. The institute shall subsequently adjust the assessment for any variation in actual and estimated expenses of the institute and for changes in hospital gross patient service revenue. Such estimated and actual expenses shall include an amount equal to the cost of fringe benefits and indirect expenses, as established by the comptroller under section 5D of chapter 29. In the event of late payment by any such hospital, the treasurer shall advance the amount of due and unpaid funds to the institute prior to the receipt of such monies in anticipation of such revenues up to the amount authorized in the then current budget attributable to such assessments and the institute shall reimburse the treasurer for such advances upon receipt of such revenues. This section shall not apply to any state institution or to any acute hospital which is operated by a city or town.

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

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

(b) With respect to any acute or non-acute hospital, the institute shall, by regulation, designate information necessary to effectuate this chapter including, but not be limited to, the filing of a charge book, the filing of cost data and audited financial statements and the submission of merged billing and discharge data. The institute shall, by regulation, designate standard systems for determining, reporting and auditing volume, case-mix, proportion of low-income patients and any other information necessary to effectuate this chapter and to prepare reports comparing acute and non-acute care hospitals by cost, utilization and outcome. Such

regulations may require such hospitals to file required information and data by electronic means; provided, however, that the institute shall allow reasonable waivers from such requirement. The institute shall, at least annually, publish a report analyzing such comparative information to assist third-party payers and other purchasers of health services in making informed decisions. Such report shall include comparative price and service information relative to outpatient mental health services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The institute shall establish by regulation at least 5 levels of registration requirements and standards for provider organizations which vary based on factors including degree of provider integration, operational size, annual net patient service revenue, related business activities including insurance and the extent to which the provider organization accepts alternative payment methodologies. One level of registration requirements and standards shall be applicable to provider organizations certified as Beacon ACOs by the health care quality and finance authority. One level of standards and registration requirements shall be designed for provider organizations that do not accept risk payments. For each level, the institute shall establish minimum registration and public reporting requirements on consumer protections and quality benchmarks.

(c)The institute shall require, at a minimum, that all provider organizations provide: (i) organizational charts showing the ownership, governance and operational structure of the

provider organization, including any clinical affiliations and community advisory boards; (ii) the number of affiliated health care professional full-time equivalents by license type, specialty, name and address of principal practice location and whether the professional is employed by the organization; (iii) the name and address of licensed facilities by license number, license type and capacity in each major service category; (iv) a comprehensive financial statement, including information on parent entities and corporate affiliates as applicable, and including details regarding annual costs, annual receipts, realized capital gains and losses, accumulated surplus and accumulated reserves; (v) Information on stop-loss insurance and any non-fee-for-service payment arrangements; (vi) information on clinical quality, care coordination and patient referral practices; (vii) information regarding expenditures and funding sources for payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical functions; (viii) information regarding charitable care and community benefit programs; (ix) for any provider organization which enters alternative payment contracts, a certification under subsection (e); and (x) such other information as the institute considers appropriate.

(d) Each registered provider organization shall annually file with the institute a comprehensive financial statement showing the organization's financial condition for the prior year, including information on parent entities and corporate affiliates as applicable and such other information as the institute may require by regulation, such as organizational or clinical information. Annual reporting shall be in a form provided by the institute and shall include, at a minimum, sufficient information to demonstrate the solvency of the provider organization and its ability to manage any alternative payment contracts into which it has entered. Any provider organization which enters or renews alternative payment contracts shall provide, with the provider organization's annual report, a certification under subsection (e). The institute may

require in writing, at any time, such additional information as is reasonable and necessary to determine the financial condition of a registered provider organization.

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

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

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

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

If the change is material, the notice shall be filed not fewer than 60 days before the date of the change. Within 30 days of receipt of a notice filed under the institute's regulations, the institute shall conduct a preliminary review to determine whether the change is likely to result in a significant impact on the commonwealth's ability to meet the health care cost growth benchmark, established in section 5 of chapter 176S, on the competitive market or on a provider organization's solvency. Material changes that are likely to result in a significant impact shall include, but not be limited to: a corporate affiliation between a provider organization and a carrier; mergers or acquisitions of hospitals or hospital systems; acquisition of insolvent provider organizations; and mergers or acquisitions of provider organizations which will result in a provider organization having a near-majority of market share in a given service or region. The institute shall specify, through regulations, other categories of material changes likely to result in significant impact. The institute may require supplementary submissions from the provider organization to provide data necessary to carry out this preliminary review. A provider organization's supplementary submissions shall be confidential and shall not be considered a

public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 until the issuance of the institute's report on its findings as a result of the preliminary review.

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

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

The institute shall initiate a cost, market impact and solvency review by sending the provider organization a notice of a cost, market impact and solvency review which shall explain the particular factors that the institute seeks to examine through the review. The institute shall notify the attorney general and the division of insurance whenever it initiates a cost, market impact and solvency review and shall issue a public notice soliciting comments to inform its review. The provider organization shall submit to the institute and the attorney general, within

21 days of the institute's notice, a written response to the notice, including, but not limited to, any information or documents sought by the institute's notice. A provider organization's written response shall be confidential and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66 only until such time as the executive director determines the response is complete.

A cost, market impact and solvency review may examine factors including, but not limited to: (i) the provider organization's size and market share within its primary service areas by major service category, and within its dispersed service areas; (ii) provider price, including its relative prices filed with the institute; (iii) provider quality, including patient experience; (iv) provider cost and cost trends in comparison to total health care expenditures statewide; (v) the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider organization within its primary service areas and dispersed service areas; (vi) the provider organization's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas; (vii) the methods used by the provider organization to attract patient volume and to recruit or acquire health care professionals or facilities; (viii) the role of the provider organization in serving at-risk, underserved and government payer patient populations within its primary service areas and dispersed service areas; (ix) the role of the provider organization in providing low margin or negative margin services within its primary service areas and dispersed service areas; (x) the financial solvency of the provider organization; (xi) consumer concerns, including but not limited to, complaints or other allegations that the provider organization has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (xii) any other factors that the institute determines to be in the public interest.

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

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

Section 11.(a) The institute may promulgate regulations necessary to ensure the uniform reporting of information from private and public health care payers, including third-party administrators, that enables the institute to analyze: (i) changes over time in health insurance premium levels; (ii) changes in the benefit and cost-sharing design of plans offered by these payers; (iii) changes in measures of plan cost and utilization; provided that this analysis shall facilitate comparison among plans and between public and private payers; and (iv) changes in type of payment methods implemented by payers and the number of members covered by alternative payment methodologies; provided, that this analysis shall facilitate comparison among plans and plan types, including the self-insured. The institute shall adopt regulations to require private and public health care payers to submit claims data, member data and provider data to develop and maintain a database of health care claims data under this chapter.

(b) The institute shall require the submission of data and other information from each private health care payer offering small or large group health plans including, but not limited to: (i) average annual individual and family plan premiums for each payer's most popular plans for a

representative range of group sizes, as further determined in regulations and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan and network designs for each plan, including whether behavioral health or other specific services are carved-out from any plans; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan, using a uniform methodology and collected under section 21 of chapter 176O; (v) information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels; (vii) health status adjusted total medical expenses by registered provider organization, provider group and local practice group and zip code calculated according to the method established under section 51 of chapter 288 of the acts of 2010; (viii) relative prices paid to every hospital, registered provider organization, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider, with hospital inpatient and outpatient prices listed separately and product type, including health maintenance organization and preferred provider organization products and determined using the method established under section 52 of chapter 288 of the acts of 2010; (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology; (x) the annual rate of growth, stated as a percentage, of the weighted average relative price by provider type and product type for the payer’s participating health care providers, whether that rate exceeds the rate of growth of the applicable producer price index as reported by the United States Bureau of Labor Statistics and identified by the commissioner of insurance and whether

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

(c) The institute shall require the submission of data and other information from public health care payers including, but not limited to: (i) average premium rates for health insurance plans offered by public payers and information concerning the actuarial assumptions that underlie these premiums; (ii) average annual per-member per-month payments for enrollees in MassHealth primary care clinician and fee for service programs; (iii) summaries of plan and network designs for each plan or program, including whether behavioral health or other specific services are carved-out from any plans; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan or program; (v) where appropriate, information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels, including information concerning payment levels to each hospital for the 25 most common medical procedures provided to enrollees in these programs, in a form that allows payment comparisons between Medicaid programs and managed care organizations under contract to the office of Medicaid; (vii) health status adjusted total medical expenses by registered provider organization, provider group and local practice group and zip code calculated according to the method established under section 51 of chapter 288 of the acts of 2010;; and (viii) relative prices paid to every hospital, registered provider organization, physician group, ambulatory surgical center, freestanding imaging center, mental

health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider, with hospital inpatient and outpatient prices listed separately, and product type and determined using the method established under section 52 of chapter 288 of the acts of 2010; (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology; (x) the annual rate of growth, stated as a percentage, of the weighted average relative price by provider type and product type for the payer’s participating health care providers, whether that rate exceeds the rate of growth of the applicable producer price index as reported by the United States Bureau of Labor Statistics and identified by the commissioner of insurance and whether that rate exceeds the rate of growth in projected economic growth benchmark established under section 7H½ of chapter 29; and (xi) a comparison of relative prices for the payer’s participating health care providers by provider type which shows the weighted average relative price, the extent of variation in price, stated as a percentage and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per cent and 20 per cent below the weighted average relative price.

(d) The institute shall require the submission of data and other information from public and private health care payers which utilize alternative payment contracts, including, but not limited to: (i) the negotiated monthly budget for each alternative payment contract in the current contract year; (ii) any applicable measures of provider performance in such alternative payment contracts; and (iii) the average negotiated monthly budget weighted by member months for each zip code.

For purposes of this subsection, payers shall report the negotiated monthly budget assuming a neutral health status score of 1.0 using an industry accepted health status adjustment

tool and shall separately report the budget allowances for: all medical and behavioral health care at both in and out-of-network providers; pharmacy coverage allowance; administrative expenses such as data analytics, health information technology, clinical program development and other program management fees; the purchase of reinsurance or stop-loss; risk reserves; and quality bonus monies, unit cost adjustments or other special allowances. If out-of-network care, behavioral health, stop-loss insurance or any other clinical services are carved out of any global budget, bundled payments or other alternative payment methodologies such that there is no allowance included in the budget for those services, payers shall report actual claims costs of these items on a per member per month basis for the year immediately prior to the current contract year.

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

Section 12. The institute shall ensure the timely reporting of information required under sections 9, 10 and 11. The institute shall notify payers, providers and provider organizations of any applicable reporting deadlines. The institute shall notify, in writing, a private health care payer, provider or provider organization, which has failed to meet a reporting deadline and that failure to respond within 2 weeks of the receipt of the notice may result in penalties. The institute may assess a penalty against a payer, provider or provider organization that fails, without just cause, to provide the requested information within 2 weeks following receipt of the written notice required under this paragraph, of up to $1,000 per week for each week of delay after the 2 week period following the payer's, provider’s or provider organization’s receipt of the written notice; provided, however, that the maximum annual penalty against a private payer under this

section shall be $50,000. Amounts collected under this section shall be deposited in the Healthcare Payment Reform Fund.

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

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

(b) The institute shall permit providers, provider organizations, public and private health care payers, government agencies and researchers to access de-identified, aggregated data collected by the institute for the purposes of lowering total medical expenses, coordinating care, benchmarking, quality analysis and other research, administrative or planning purposes, provided, that such data shall not include information that would allow the identification of the

health information of an individual patient or the disclosure of rates of payment in individual provider agreements. The institute shall charge user fees sufficient to defray the institute's cost of providing such access to non-governmental entities.

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

Section 15. (a) The institute shall publish an annual report based on the information submitted under sections 9, 10 and 11 concerning health care provider, provider organization and private and public health care payer costs and cost trends. The institute shall compare such costs and cost trends with the health care cost growth benchmark established by the health care quality and finance authority under section 5 of chapter 176S and shall detail: (i) baseline information about cost, price, quality, utilization and market power in the commonwealth's health care system; (ii) factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates; (iii) the impact of health care reform efforts on health care costs including, but not limited to, the development of limited and tiered networks, increased price transparency, increased utilization of electronic medical

records and other health technology and increased prevalence of alternative payment contracts and provider organizations with integrated care networks; (iv) price variance between providers and any efforts undertaken by payers to reduce such variance; (v) trends in utilization of unnecessary or duplicative services, with particular emphasis on imaging and other high-cost services (vi) the prevalence and trends in adoption of alternative payment methodologies and impact of alternative payment methodologies on overall health care spending, insurance premiums and provider rates; and (vii) the development and status of provider organizations in the commonwealth including, but not limited to, the formation of provider organizations with integrated care networks, acquisitions, mergers, consolidations and any evidence of excess consolidation or anti-competitive behavior by provider organizations.

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

(b) The attorney general may review and analyze any information submitted to the institute under said sections 9, 10 and 11. The attorney general may require that any provider, provider organization or payer produce documents, answer interrogatories and provide testimony under oath related to health care costs and cost trends or documents that the attorney general considers necessary to evaluate factors that contribute to cost growth within the commonwealth's health care system and to the relationship between provider costs and payer premium rates. The attorney general shall keep confidential all nonpublic information and documents obtained under this section and shall not disclose such information or documents to any person without the consent of the provider or payer that produced the information or documents except in a public

hearing under section 6 of chapter 176S, a rate hearing before the division of insurance or in a case brought by the attorney general, if the attorney general believes that such disclosure will promote the health care cost containment goals of the commonwealth and that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anti-competitive considerations. Such confidential information and documents shall not be public records and shall be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of chapter 66.

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

(d) The institute shall provide technical assistance to the health care quality and finance authority, in compiling the annual report required by section 6 of chapter 176S including, but not limited to, providing access to any data collected by the institute under sections 9, 10 and 11 and providing analysis regarding spending trends and factors underlying such spending trends.

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

of such payers, providers and provider organizations to the health care quality and finance authority such that the authority may pursue further action under section 7 of chapter 176S.

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

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

Section 18. The institute shall review and comment upon all capital expenditure projects requiring a determination of need under section 25C of chapter 111, including, but not limited to, the availability and accessibility of services similar to those provided, or proposed to be provided, through the provider organization within its primary service areas and dispersed service areas; the provider organization's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas; less costly or more effective alternative financing methods for such projects; the immediate and long-term financial

feasibility of such projects; the probable impact of the project on costs of and charges for services; and the availability of funds for capital and operating needs. The institute shall transmit to the department of public health its written recommendations on each project which shall become part of the written record compiled by said department during its review of such project. The institute shall appear and comment on any application for a determination of need where a public hearing is required under said section 25C of said chapter 111. To carry out this paragraph, the institute shall appoint a senior professional employee to act as a liaison with said department.

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

Section 20. The institute shall, in consultation with the health care quality and finance authority, maintain a consumer health information website. The website shall contain information comparing the quality, price and cost of health care services and may also contain general health care information as the institute considers appropriate. The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices among health care providers. Information shall be presented in a format that is understandable to the average consumer. The institute shall take appropriate action to publicize the availability of its website.

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

The institute shall, after due consideration and public hearing, adopt the reporting plan and adopt or reject any revisions. If the institute rejects the reporting plan or any revisions, the institute shall state its reasons for the rejection. The reporting plan and any revisions adopted by the institute shall be promulgated by the institute. The institute shall submit the reporting plan and any periodic revisions to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and the clerks of the house and senate.

The website shall provide updated information on a regular basis, at least annually, and additional comparative quality, price and cost information shall be published as determined by the institute. To the extent possible, the website shall include: (i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative price and cost information is provided; (ii) general information

related to each service or category of service for which comparative information is provided; (iii) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction; and (iv) data concerning healthcare-acquired infections and serious reportable events reported under section 51H of chapter 111.

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

Section 22. Any provider of health care services that receives reimbursement or payment for treatment of injured workers under chapter 152 and any provider of health care services other than an acute or non-acute hospital that receives reimbursement or payment from any governmental unit for general health supplies, care and rehabilitative services and accommodations, shall, as a condition of such reimbursement or payment: (1) permit the executive director, or the executive director's designated representative and the attorney general or a designee, to examine such books and accounts as may reasonably be required for the

institute to perform its duties; (2) file with the executive director from time to time or on request, such data, statistics, schedules or other information as the institute may reasonably require, including outcome data and such information regarding the costs, if any, of such provider for research in the basic biomedical or health delivery areas or for the training of health care personnel which are included in the provider's charges to the public for health care services, supplies and accommodations; and (3) accept reimbursement or payment at the rates established by the secretary of health and human services or a governmental unit designated by the executive office, subject to a right of appeal under section 13E of chapter 118E, as discharging in full any and all obligations of an eligible person and the governmental unit to pay, reimburse or compensate the provider of health care services in any way for general health supplies, care and rehabilitative services or accommodations provided.

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

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

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

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

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

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

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

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

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

"Projected economic growth benchmark," the long-term average projected percentage change in the per capita state's gross state product, excluding business cycles.

(b) On or before January 15, the secretary of administration and finance shall meet with the house and senate committees on ways and means and shall jointly develop a projected economic growth benchmark for the ensuing calendar year which shall be agreed to by the secretary and said committees. In developing a projected economic growth benchmark the secretary and said committees, or subcommittees of said committees, may hold joint hearings on the economy of the commonwealth; provided, however, that in the first year of the term of office of a governor who has not served in the preceding year, said parties shall agree to the projected economic growth benchmark not later than January 31 of said year. The secretary and the committees may agree to incorporate this hearing into any consensus tax revenue forecast hearing held under section 5B. The projected economic growth benchmark shall be included with the consensus tax revenue forecast joint resolution under said section 5B and placed before the members of the general court for their consideration. Such joint resolution, if passed by both branches of the general court, shall establish the projected economic growth benchmark to be used by the health care quality and finance authority to establish the health care cost growth benchmark under section 5 of chapter 176S.

(c) Not later than September 15 of each year, the secretary shall report the actual economic growth benchmark for the previous calendar year, based on the best information

available at the time. The information shall be provided to the health care quality and finance authority established under chapter 176S.

SECTION 19. Section 2OOO of chapter 29 of the General Laws, as so appearing, is hereby amended by striking out, in line 6, the words “18B of chapter 118G” and inserting in place thereof the following words:- 18 of chapter 176Q.

SECTION 20. Said section 2OOO of said chapter 29, as so appearing, is hereby further amended by striking out, in line 16, the words “established by section 18 of chapter 118G”.

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

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

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

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

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

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

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

The board shall consist of the following members: the secretary of labor and workforce development, who shall serve as chair; the executive director of the institute of health care finance and policy or a designee; the commissioner of public health or a designee, and no more than 13 members who shall be appointed by the secretary of labor and workforce development and who shall reflect a broad distribution of diverse perspectives on the health care system and

health care workforce needs, including health care professionals, labor organizations, educational institutions, consumer representatives, providers and payers.

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

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

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

(ii) address critical workforce shortages;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(h) The comptroller shall annually transfer not less than 10% of available funds in the Health Care Workforce Transformation Trust Fund to the Massachusetts Nursing and Allied Health Workforce Development Trust Fund established in section 33 of chapter 305 of the acts

of 2008 to develop and support strategies that increase the number of public higher education faculty members and students who participate in programs that support careers in fields related to nursing and allied health.

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

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

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

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

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

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

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

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

(b) There shall be established a health information technology council within the corporation. The council shall advise the institute on the dissemination of health information technology across the commonwealth, including the deployment of interoperable electronic

health records systems in all health care provider settings that are networked through a statewide health information exchange.

The council shall consist of 15 members: 1 of whom shall be the secretary of administration and finance, who shall serve as chair; 1 of whom shall be the secretary of health and human services; 1 of whom shall be the executive director of the institute of health care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic development or a designee; 11 of whom shall be appointed by the governor, of whom at least 1 shall be an expert in health information technology, 1 of whom shall be an expert in state and federal health privacy laws, 1 of whom shall be an expert in the health policy, 1 of whom shall be an expert in health information technology relative to privacy and security, 1 of whom shall be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of whom shall be from a physician group practice, and 2 of whom shall represent the health insurance carriers. The council may consult with such parties, public or private, as it deems desirable in exercising its duties under this section, including persons with expertise and experience in the development and dissemination of interoperable electronic health records systems, and the implementation of interoperable electronic health record systems by small physician groups or ambulatory care providers, as well as persons representing organizations within the commonwealth interested in and affected by the development of networks and interoperable electronic health records systems, including, but not limited to, persons representing local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, physicians, health insurers and health plans, the state quality improvement organization, academic and research institutions,

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

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

(c) The institute, in consultation with the council, shall advance the dissemination of health information technology and support the state's efforts in meeting the health care cost growth benchmark established under section 5 of chapter 176S by: (i) facilitating the implementation and use of interoperable electronic health records systems by health care providers in order to improve health care delivery and coordination, reduce unwarranted treatment variation, eliminate wasteful paper-based processes, help facilitate chronic disease management initiatives and establish transparency; (ii) facilitating the creation and maintenance of a statewide interoperable electronic health records network that allows individual health care providers in all health care settings to exchange patient health information with other providers;(iii) identifying and promoting an accelerated dissemination in the commonwealth of

emerging health care technologies that have been developed and employed and that are expected to improve health care quality and lower health care costs, but that have not been widely implemented in the commonwealth, including, but not limited to, evidence-based clinical decision support tools for advanced diagnostic imaging services; (iv) facilitating health care providers in achieving and maintaining compliance with the standards for meaningful use, beyond stage 1, established by regulation by the United States Department of Health and Human Services under the Health Information Technology for Economic and Clinical Health Act and referred to in this section as "meaningful use"; and (v) promoting to patients, providers and the general public, a broad understanding of the benefits of interoperable electronic health records systems for care delivery, care coordination, improved quality and ultimately greater cost efficiency in the health care delivery system.

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

Components of each such plan, as updated, shall be community-based implementation plans that assess a municipality's or region's readiness to implement and use electronic health record systems and an interoperable electronic health records network within the referral market for a defined patient population. Each such implementation plan shall address the development, implementation and dissemination of interoperable electronic health records systems among health care providers in the community or region, particularly providers, such as community

health centers that serve underserved populations, including, but not limited to, racial, ethnic and linguistic minorities, uninsured persons and areas with a high proportion of public payer care.

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

(e) The corporation may contract with implementing organizations to: (i) facilitate a public-private partnership that includes representation from hospitals, physicians and other health care professionals, health insurers, employers and other health care purchasers, health data and service organizations and consumer organizations; (ii) provide resources and support to recipients of grants awarded under subsection (f) to implement each program within the designated community pursuant to the implementation plan; (iii) certify and disburse funds to subcontractors, when necessary; (iv) provide technical assistance to facilitate successful practice redesign, adoption of electronic health records and utilization of care management strategies; (v) ensure that electronic health records systems are fully interoperable and secure and that sensitive patient information is kept confidential by exclusively utilizing electronic health records

products that are certified by the Office of the National Coordinator under the federal Health Information Technology for Economic and Clinical Health Act; and (vi) certify, with approval of the corporation, a group of subcontractors who shall provide the necessary hardware and software for system implementation. Prior to the institute's issuing requests for proposals for contracts to be entered into under this section, the institute's director shall consult with the council with respect to the content of all such proposals.

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

mental health facilities, chronic care and rehabilitation hospitals, skilled nursing facilities, visiting nursing associations, home health providers, registered nurses, licensed practical nurses, physicians, physician assistants, chiropractors, dentists, occupational therapists, physical therapists, optometrists, pharmacists, podiatrists, psychologists and social workers. In making the determinations regarding available resources as described in clauses (i) and (ii), the director of the institute shall consider:

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

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

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

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

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

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

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

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

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

All grants shall be recommended by the institute director and subsequently approved by the executive director. The institute director shall work with implementation organizations to oversee the grant-making process as it relates to an implementing organization's responsibilities under its contract with the corporation. Each recipient of monies from this program shall: (i) capture and report certain quality improvement data, as determined by the institute in consultation with the department of public health and the institute of health care finance and policy; (ii) fully implement an electronic health record system, including all clinical features, with such interoperability as may be feasible at the time, not later than the second year of the grant; and (iii) make use of the system's full range of features. In the event that any recipient of grant monies from this program does not achieve installation of a fully functioning electronic health record system or does not achieve the appropriate level of interoperability within the 2 year grant period, such recipient shall be required to repay to the corporation all or some portion,

as determined by the corporation, of the grant funds previously provided to such recipient under this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Anatomic pathology service", histopathology, surgical pathology, cytopathology, hematology, subcellular pathology, molecular pathology and blood-banking services performed by a pathologist.

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

"Cytopathology", the examination of cells from the following:

(i) fluids;

(ii) aspirates;

(iii) washings;

(iv) brushings; or

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

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

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

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

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

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

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

(i) the patient directly;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Commissioner", the commissioner of medical assistance or the secretary of elder affairs, as appropriate.

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

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

"Department", the department of elder affairs.

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

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

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

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

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

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

"Enrollee", a person who becomes a member of an insurance program of the division either individually or as a member of a family.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Institution", a licensed hospital, nursing home or public medical institution that meets the requirements of the secretary.

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

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

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

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

"Medical benefits", benefits provided under section 9A.

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

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

"Patient", a natural person receiving health care services from a hospital.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Social service program provider", a provider of social service programs in the commonwealth.

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

"Specialty hospital", an acute hospital which qualifies for an exemption from the Medicare prospective payment system regulations or an acute hospital which limits its

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

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

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

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

"Title XXI", Title XXI of the Social Security Act, 42 USC 1397 et seq. or any successor thereto.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Unrestricted income from endowment funds", income earned on investment of endowment funds which have no restrictions on income.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) The fund shall consist of all amounts paid by acute hospitals and surcharge payors under sections 67 and 68; all appropriations for the purpose of payments to acute hospitals or community health centers for health services provided to uninsured and underinsured residents; any transfers from the Commonwealth Care Trust Fund, established under section 2OOO of chapter 29; and all property and securities acquired by and through the use of monies belonging to the fund and all interest thereon. Amounts placed in the fund shall, except for amounts transferred to the Commonwealth Care Trust Fund, be expended by the office for payments to hospitals and community health centers for reimbursable health services provided to uninsured and underinsured residents of the commonwealth, consistent with the requirements of this section and section 69 and the regulations promulgated by the office; provided, however, that expenses of the health safety net office under subsection (a) shall be expended annually from the fund; and provided further, that not more than $6,000,000 shall be expended annually from the fund for demonstration projects that use case management and other methods to reduce the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Consumer," a person to whom a personal care attendant provides personal care services.

"PCA quality home care workforce council", "workforce council" or "the council", the Personal Care Attendant quality home care workforce council established under section 72.

"Personal care attendant," a person, including a personal aide, who has been selected by a consumer or the consumer's surrogate to provide personal care services to persons with disabilities or seniors under the MassHealth personal care attendant program or any successor program.

"Surrogate" means the consumer's legal guardian or person identified in a written agreement with the consumer as responsible for hiring, directing and firing on behalf of the consumer.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 146. Section 15 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 2, 3, 5 and 6, 6, 9, 22, 25, 27, 46 and 47, 47, 49, 52, 60, 71 and 74, the word "physician" and inserting in place thereof, in each instance, the following word:- provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) not exceed 2 pages;

(2) be made electronically available; and

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

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

(1) seek input from interested stakeholders;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

the connector not later than 3 months after the end of each hospital fiscal year, with payment by non-providing employers not later than 180 days after the assessment. The amount charged by the connector shall be greater than 10 per cent but not greater than 100 per cent of the cost to the state of the services provided to the state-funded employee, considering all payments received by the state from other financing sources for free care; provided that the "cost to the state" for services provided to any state-funded employee may be determined by the connector as a percentage of the state's share of aggregate costs for health services. The free rider surcharge shall only be triggered upon incurring $50,000 or more, in any hospital fiscal year, in free care services for any employer's employees, or dependents of such persons, in aggregate, regardless of how many state-funded employees are employed by that employer.

(c) The formula for assessing free rider surcharges on non-providing employers shall be set forth in regulations promulgated by the connector that shall be based on factors including, but not limited to: (i) the number of incidents during the past year in which employees of the non-providing employer received services reimbursed by the health safety net office under section 69 of chapter 118E; (ii) the number of persons employed by the non-providing employer; (iii) the proportion of employees for whom the non-providing employer provides health insurance.

(d) If a state-funded employee is employed by more than 1 non-providing employer at the time the employee receives services, the connector shall assess a free rider surcharge on each said employer consistent with the formula established by the connector under this section.

(e) The connector shall specify by regulation appropriate mechanisms for implementing free rider surcharges on non-providing employers. Said regulations shall include, but not be limited to, the following:—

(i) appropriate mechanisms that provide for determination and payment of surcharge by a non-providing employer including requirements for data to be submitted by employers, employees, acute hospitals and ambulatory surgical centers, and other persons; and

(ii) penalties for nonpayment or late payment by the non-providing employer, including assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.

(f) All surcharge payments made under this section shall be deposited into the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29.

(g) A non-providing employer's liability to that fund shall in the case of a transfer of ownership be assumed by the successor in interest to the non-providing employer's.

(h) If a non-providing employer fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the connector, the connector shall provide written notice of the required information. If the employer fails to provide information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject to a civil penalty of not more than $5,000 for each week on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction.

(i) The attorney general shall bring any appropriate action, including injunctive relief, as may be necessary for the enforcement of this section.

(j) No employer shall discriminate against any employee on the basis of the employee's receipt of free care, the employee's reporting or disclosure of the employer's identity and other information about the employer, the employee's completion of a Health Insurance Responsibility Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed against the employer in relation to the employee. Violation of this subsection shall constitute a per se violation of chapter 93A.

(k) A hospital, surgical center, health center or other entity that provides health safety net services shall provide an uninsured patient with written notice of the criminal penalties for committing fraud in connection with the receipt of health safety net services. The connector shall promulgate a standard written notice form to be made available to health care providers in English and foreign languages. The form shall further include written notice of every employee's protection from employment discrimination under this section.

SECTION 162. The General Laws are hereby amended by inserting, after chapter 176R the following 2 chapters:

CHAPTER 176S

COMMONWEALTH HEALTH CARE QUALITY AND FINANCE AUTHORITY

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

"Actual economic growth benchmark," the actual annual percentage change in the per capita state's gross state product, excluding the impact of business cycles, as established under section 7H½ of chapter 29.

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

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

"Alternative payment methodologies", methods of payment that are not directly fee-for-service reimbursement for services; provided, that "alternative payment methodologies" may include, but not be limited to, global payments, shared savings arrangements, bundled payments and episodic payments.

"Authority", the commonwealth health care quality and finance authority.

"Beacon ACO", a certification given by the board of the authority to indicate that a provider organization meets certain standards regarding quality, cost containment and patient protection.

"Board", the board of the commonwealth health care quality and finance authority, established by section 2.

"Business entity", a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

"Carrier," an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter

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

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

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

“Institute”, the institute of health care finance and policy established in chapter 12C.

“Health benefit plan”, any individual, general, blanket or group policy of health, accident and sickness insurance issued by an insurer licensed under chapter 175; a group hospital service plan issued by a non-profit hospital service corporation under chapter 176A; a group medical service plan issued by a non-profit medical service corporation under chapter 176B; a group health maintenance contract issued by a health maintenance organization under chapter 176G; a

coverage for young adults health insurance plan under section 10 of chapter 176J; provided that "health benefit plan" shall not include accident only, credit-only, limited scope vision or dental benefits if offered separately, hospital indemnity insurance policies if offered as independent, non-coordinated benefits which for the purposes of this chapter shall mean policies issued under chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner of insurance by regulation may set, insurance arising out of a workers compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. section 55 if offered as a separate insurance policy, or any policy subject to chapter 176K or any similar policies issued on a group basis, Medicare Advantage plans or Medicare Prescription drug plans; provided, further that "health benefit plan" shall not include a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program under section 18 of chapter 15A which shall be governed by said chapter 15A; provided, further that the authority may by regulation define other health coverage as a health benefit plan for the purposes of this chapter.

"Health care cost growth benchmark," the projected annual percentage change in total health care expenditures in the commonwealth, as established in section 5.

"Health care entity", a provider, provider organization or carrier.

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

"Health care services," services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

"Health status adjusted total medical expenses", the total cost of care for the patient population associated with a provider group based on allowed claims for all categories of medical expenses and all non-claims related payments to providers, adjusted by health status and expressed on a per member per month basis, as calculated under section 9 of chapter 12C.

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

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

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

"Performance improvement plan," a plan submitted to the authority by a carrier, a provider or a provider organization under section 7, which shall be kept confidential by the board and shall not be considered a public record under clause Twenty-sixth of section 7 of chapter 4 or chapter 66.

"Projected economic growth benchmark," the long-term average projected percentage chance in the per capita state's gross state product, excluding the impact of business cycles, as established under section 7H½ of chapter 29.

"Provider," a health care professional or a facility.

"Provider organization," any corporation, partnership, business trust, association or organized group of persons whether incorporated or not that consists of or represents 1 or more providers in contracting with carriers for the payments the provider or providers receive for the provision of heath care services; provided, that "provider organization" shall include, but not be limited to, physician organizations, physician-hospital organizations, independent practice associations, accountable care organizations, provider networks and any other organization that contracts with carriers for payment for health care services.

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

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

Section 2. (a) There shall be a body politic and corporate and a public instrumentality to be known as the commonwealth health care quality and finance authority, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth except as specifically provided in any general or special law. The exercise by the authority of the powers conferred by this chapter shall be considered to be the performance of an essential public function. The purpose of the authority shall be to set health care cost containment goals for the commonwealth and to foster innovative health care delivery and payment models that lower health care cost growth while improving the quality of patient care.

(b) There shall be a board, with duties and powers established by this chapter, that shall govern the authority. The authority's board shall consist of 11 members: the secretary of administration and finance, ex officio; the secretary of health and human services, ex officio; the secretary of housing and economic development, ex officio; 1 other member appointed by the governor whom shall be an expert in health care delivery and payment models; 3 members appointed by the attorney general, 1 of whom shall be a health economist, 1 of whom shall represent the interests of businesses and 1 of whom shall have experience in the administration

of a health care provider organization; 3 members appointed by the state auditor, 1 of whom shall be an expert in behavioral health services and behavioral health reimbursement systems, 1 of whom shall be a representative of a health consumer organization and 1 of whom shall be a representative of organized labor. The governor, attorney general and the auditor shall, by majority vote, jointly appoint 1 member who is an expert in health care finance and policy in the commonwealth, to act as the chair. All members shall serve a term of 3 years, but a member appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. The board shall annually elect 1 of its members to serve as the vice-chairperson. Each member of the board serving ex officio may appoint a designee under section 6A of chapter 30.

(c) A member of the board shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, have a financial stake in or otherwise be a representative of a health care entity while serving on the board.

(d) Six members of the board shall constitute a quorum and the affirmative vote of 6 members of the board shall be necessary and sufficient for any action taken by the board. No vacancy in the membership of the board shall impair the right of a quorum to exercise all the rights and duties of the connector. Members shall serve without pay but shall be reimbursed for actual expenses necessarily incurred in the performance of their duties. The chairperson of the board shall report to the governor and to the general court not less frequently than annually.

(e) Any action of the authority may take effect immediately and need not be published or posted unless otherwise provided by law. Meetings of the board shall be subject to section 11A of chapter 30A; but, said section 11A shall not apply to any meeting of members of the board

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

(f) The chairperson shall hire an executive director to supervise the administrative affairs and general management and operations of the authority and also serve as secretary of the authority, ex officio. The executive director shall receive a salary commensurate with the duties of the office. The executive director may appoint other officers and employees of the authority necessary to the functioning of the authority. Sections 9A, 45, 46 and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the authority. The executive director shall, with the approval of the board:

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

(ii) employ professional and clerical staff as necessary;

(iii) report to the board on all operations under the executive director’s control and supervision;

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

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

Section 3. The board of the authority shall set health care cost containment goals for the commonwealth and foster the innovation of health care delivery and payment models that lower health care cost growth while improving the quality of patient care. The board shall have all powers necessary or convenient to carry out and effectuate its purposes including, but not limited to, the power to:

(a) to develop a plan of operation for the authority, which shall include, but not be limited to:

(1) establishing procedures for operations of the authority;

(2) establishing procedures for communications with the executive director;

(3) establishing procedures for setting an annual health care cost growth benchmark;

(4) holding annual hearings concerning the growth in total health care expenditures relative to the health care cost benchmark, including an examination of health care provider, provider organization and payer costs, prices and health status adjusted total medical expense trends;

(5) providing an annual report on recommendations for strategies to meet future annual health care cost growth benchmarks and to promote an efficient health delivery system;

(6) establishing procedures that, in the event the annual health care cost growth benchmark is exceeded, require certain health care entities to file a performance improvement plan and the procedures for approving said plan;

(7) establishing procedures for monitoring compliance and implementation by a health care entity of a performance improvement plan, including standards to ascertain whether a health care entity has failed to implement a performance improvement plan in good faith;

(8) establishing procedures and developing criteria for the certification of certain provider organizations as Beacon ACOs, based on standards related to cost containment, quality improvement and patient protections;

(9) establishing procedures to decertify certain provider organizations as Beacon ACOs;

(10) developing best practices and standards for alternative payment methodologies to be adopted by the office of Medicaid, the group insurance commission and other state-funded health insurance programs;

(11) fostering health care innovation by identifying, developing, supporting and evaluating health care delivery and payment reform models and best practices, in consultation with health care entities, that reduce health care cost growth while improving the quality of patient care; and

(12) administering the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of 2011, to support the activities of the authority;

(b) to adopt by-laws for the regulation of its affairs and the conduct of its business;

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

(d) to maintain an office at such place or places in the commonwealth as it may designate;

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

(f) to establish lines of credit, and establish 1 or more cash and investment accounts to receive payments for services rendered, appropriations from the commonwealth and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974;

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

(h) to enter into interdepartmental agreements with the institute of health care finance and policy, the executive office of health and human services, the division of insurance and any other state agencies the board considers necessary.

Section 4. There shall be an advisory board to the authority. The advisory board shall advise on the overall operation and policy of the authority. The advisory board shall consist of 7 ex-officio members, including the state auditor, the inspector general, the attorney general, the commissioner of insurance, the executive director of the institute of health care finance and policy, the commissioner of public health and the executive director of the group insurance commission, or their designees; and 11 additional members to be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid Services, 1 of whom shall be a representative of

the Institute for Healthcare Improvement recommended by the organization's board of directors, 1 of whom shall be a representative of the Massachusetts chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, Inc., 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, Inc., 1 of whom shall be a expert in health care policy from a foundation or academic institution, 1 of whom shall be a representative of a non-governmental purchaser of health insurance, 1 of whom shall be an organization representing the interests of small businesses with fewer than 50 employees, 1 of whom shall be an organization representing the interests of large businesses with 50 or more employees, 1 of whom shall be a physician licensed to practice in the commonwealth and 1 of whom shall be a non-physician health care professional licensed to practice in the commonwealth.

Section 5. (a) Not later than April 15 of every year, the board shall establish a health care cost growth benchmark for the average growth in total health care expenditures in the commonwealth for the next calendar year. The authority shall establish procedures to prominently publish the annual health care cost growth benchmark on the authority’s website.

(b) For calendar years 2012-2015, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 0.5%.

(c) For calendar years 2016-2022, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29.

(c) For calendar years 2027 and thereafter, the health care cost growth benchmark shall be equal to the economic growth benchmark established under section 7H½ of chapter 29, plus 1%.

Section 6. (a) Not later than October 1 of every year, the board shall hold public hearings based on the report submitted by the institute under section 15 of chapter 12C comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year. The hearings shall examine health care provider, provider organization and private and public health care payer costs, prices, and cost trends, with particular attention to factors that contribute to cost growth within the commonwealth's health care system. The attorney general may intervene in such hearings.

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

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

(d) Witnesses shall provide testimony under oath and subject to examination and cross examination by the board, the executive director of the institute and the attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) in the case of providers and provider organizations, testimony concerning payment systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization trends, relative price, quality improvement and care-coordination strategies, investments in health information technology, the relation of private payer reimbursement levels to public payer reimbursements for similar services, efforts to improve the efficiency of the delivery system and efforts to reduce the inappropriate or duplicative use of technology; and (ii) in the case of private and public payers, testimony concerning factors underlying premium cost and rate increases, the relation of reserves to premium costs, the payer's efforts to develop benefit design, network design and payment policies that enhance product affordability and encourage efficient use of health resources and technology including utilization of alternative payment methodologies, efforts by the payer to increase consumer access to health care information, efforts by the payer to reduce price variance between providers, efforts by the payer to promote the standardization of administrative practices and any other matters as determined by the board.

(e) In the event that the institute's annual report under section 15 of chapter 12C finds that the percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, the authority may identify additional witnesses for the public hearing. Witnesses shall provide testimony subject to examination and cross examination by the board, the executive director of the institute and attorney general at the public hearing in a manner and form to be determined by the board, including without limitation: (i) testimony

concerning unanticipated events that may have impacted the total health care cost expenditures, including, but not limited to, a public health crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony concerning trends in patient acuity, complexity or utilization of services; (iii) testimony concerning trends in input cost structures, including, but not limited to, the introduction of new pharmaceuticals, medical devices and other health technologies; (iv) testimony concerning the cost of providing certain specialty services, including but not limited to, the provision of health care to children, the provision of cancer-related health care and the provision of medical education; (v) testimony related to unanticipated administrative costs for carriers, including, but not limited to, costs related to information technology, administrative simplification efforts, labor costs and transparency efforts; (vi) testimony related to costs due the implementation of state or federal legislation or government regulation; and (vii) any other factors that may have led to excessive health care cost growth.

(f) The authority shall compile an annual report concerning spending trends and underlying factors, along with any recommendations for strategies to increase the efficiency of the health care system. The report shall be based on the authority's analysis of information provided at the hearings by providers, provider organizations and insurers, data collected by the institutes under sections 9 t10 and11 of chapter 12C, and any other information the authority considers necessary to fulfill its duties under this section, as further defined in regulations promulgated by the authority. The report shall be submitted to the chairs of the house and senate committees on ways and means, the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include any legislative language necessary to implement the recommendations.

Section 7. (a) The authority shall provide confidential notice to health care entities whose increase in health status adjusted total medical expense is considered excessive and who threaten the ability of the state to meet the health care cost growth benchmark as identified by the institute under section 16 of chapter 12C. Such notice shall state that the health care entity has been identified as having an excessive increase in health status adjusted total medical expense.

(b) For calendar year 2015, in the event that the institute's annual report under section 15 of chapter 12C finds that average percentage change in cumulative total health care expenditures from 2012 to 2014 exceeded the average health care cost benchmark from 2012 to 2014, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in section 5, the authority shall establish procedures to assist health care entities to improve efficiency and reduce cost growth through the requirement of certain health care entities to file and implement a performance improvement plan.

Beginning in calendar year 2016, in the event that the institute's annual report under said section 15 of said chapter 12C finds that percentage change in total health care expenditures exceeded the health care cost benchmark in the previous calendar year, and in order to support the state's efforts to meet future health care cost growth benchmarks, as established in said section 5, the authority shall establish procedures to assist health care entities to improve efficiency and reduce the cost growth through the requirement of certain health care entities to file and implement a performance improvement plan.

(c) In addition to the confidential notice provided under subsection (a), the authority may provide confidential notice to the health care entity that it will be required to file a performance

improvement plan. Within 45 days of receiving this notice from the authority, the health care entity shall either:

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

(2) file a confidential application with the authority to waive or extend the requirement to file a performance improvement plan. The health care entity may file any documentation or supporting evidence with the authority to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The authority shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application.

All information submitted shall remain confidential and exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 and chapter 66.

(d) The authority may waive or delay the requirement for a health care entity to file a performance improvement plan in response to a waiver or extension request filed under paragraph (2) of subsection (c) based on a consideration of the following factors, in light of all information received from the health care entity:

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

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

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

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

(5) the proportionate impact of the health care entity's costs on the growth of total health care medical expenses statewide;

(6) a significant deviation between the projected economic growth benchmark and the actual economic growth benchmark, as established under section 7H½ of chapter 29; and

(7) any other factors the authority considers relevant, including any information or testimony collected by the authority under the subsection (e) of section 6.

If the authority declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the authority shall provide confidential notice to the health care entity that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan within 45 days.

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

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

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

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

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

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

(k) Upon the successful completion of the performance improvement plan, or a decision by the board to waive or delay the requirement to file a new performance improvement plan, the identity of the health care entity shall be removed from the authority's website.

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

(m) The authority may submit a recommendation of proposed legislation to the joint committee on health care financing if the authority believes that further legislative authority is

needed to assist health care entities to implement successful performance improvement plans or to ensure compliance under this section.

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

Section 8. (a) The authority, in consultation with the advisory board, shall develop standards and a common application form for certain provider organizations to be voluntarily certified as Beacon ACOs. The purpose of the Beacon ACO certification process shall be to encourage the adoption of certain best practices by provider organizations in the commonwealth related to cost containment, quality improvement and patient protection. Provider organizations seeking this certification shall apply directly to the authority and shall submit all necessary documentation as required by the authority. The Beacon ACO certification shall be assigned to all provider organizations that meet the standards developed by the board.

(b) In developing standards for Beacon ACO certification, the authority shall include a review of the best practices employed by health care entities in the commonwealth, and at a minimum, all applicable requirements developed by the Centers for Medicare & Medicaid Services under the Pioneer ACO model, including, but not limited to, requirements that all Beacon ACOs shall: (i) commit to entering alternative payment methodology contracts with other purchasers such that the majority of the Beacon ACO's total revenues will be derived from such arrangements; (ii) be a legal entity with its own tax identification number, recognized and authorized under the laws of the commonwealth; (iii) include patient and consumer

representation on its governance; and (iv) commit to ensuring at least 50 per cent of the Beacon ACO's primary care providers are meaningfully using certified EHR technology as defined in the HITECH Act and subsequent Medicare regulations.

(c) The board shall develop additional standards necessary to be certified as a Beacon ACO, related to quality improvement, cost containment and patient protections. In developing additional standards, the board shall consider, at a minimum, the following requirements for Beacon ACOs:

(1) to reduce the growth of health status adjusted total medical expenses over time, consistent with the state's efforts to meet the health care cost benchmark established under section 5;

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

(3) to ensure patient access to health care services across the care continuum, including, but not limited to, access to: preventive and primary care services; emergency services; hospitalization services; ambulatory patient services; mental health and behavioral health services; access to specialty care units, including, but are not limited to, burn, coronary care, cancer care, neonatal care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical, including trauma and intensive care units; pediatric services; diagnostic imaging and screening services; maternity and newborn care services; radiation therapy and treatment services; skilled nursing facilities; family planning services; home health services; treatment and prevention services for alcohol and other drug abuse; breakthrough technologies and treatments; and allied health services including, but not limited to, advance

practice nurses, optometric care, direct access to chiropractic services, occupational therapists, dental care, physical therapy and midwifery services;

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

(5) to improve access to health care services and quality of care for vulnerable populations including, but not limited to, children, the elderly, low-income individuals, individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities.

(6) to promote the integration of mental health and behavioral health services with primary care services including, but not limited to, the establishment of a behavioral health medical home;

(7) to promote patient-centeredness by, including, but not limited to, establishing mechanisms to conduct patient outreach and education on the necessity and benefits of care coordination; demonstrating an ability to engage patients in shared decision making taking into account patient preferences; demonstrating an ability to effectively involve patients in care transitions to improve the continuity and quality of care across settings, with case manager follow up; demonstrating an ability to engage and activate patients at home, through methods such as home visits or telemedicine, to improve self-management; and establishing mechanisms to evaluate patient satisfaction with the access and quality of their care;

(8) to adopt certain health information technology and data analysis functions, including, but not limited to, population-based management tools and functions; the ability to aggregate and analyze clinical data; the ability to electronically exchange patient summary

records across providers who are members of the Beacon ACO and other providers in the community to ensure continuity of care; the ability to provide access to multi-payer claims data and performance reports and the ability to share performance feedback on a timely basis with participating providers; and the ability to enable the beneficiary access to electronic health information;

(9) to demonstrate excellence in the area of quality improvement and care coordination, as evidenced by the success of previous or existing care coordination, pay for performance, patient centered medical home, quality improvement or health outcomes improvement initiatives, including, but not limited to, a demonstrated commitment to reducing avoidable hospitalizations, adverse events and unnecessary emergency room visits;

(10) to promote community-based wellness programs and community health workers, consistent with efforts funded by the department of public health through the Prevention and Wellness Trust Fund established in section 2G of chapter 111;

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

(12) to adopt certain governance structure standards;

(13) to adopt certain financial capacity standards, including certification under subsection (e) of section 10 of chapter 12C, to protect Beacon ACOs from assuming excess risk; and

(14) any other requirements the board considers necessary.

(d) The authority shall update the standards for certification as a Beacon ACO at least every 2 years, or at such other times as the authority determines necessary. In developing the standards, the authority shall seek to allow for provider organizations of different compositions, including, but not limited to, physician group entities and independent physician organizations, to successfully apply for certification.

(e) Provider organizations shall annually renew their certification as a Beacon ACO. Failure to meet the requirements represented in the certification may result in decertification, as determined by the board.

Section 9. (a) The authority, in consultation with the advisory board, shall develop best practices and standards for alternative payment methodologies for use by the group insurance commission, the office of Medicaid and any other state funded insurance program. Any alternative payment methodology shall: (1) support the state's efforts to meet the health care cost benchmark established in section 5; (2) include incentives for higher quality care; (3) include a risk adjustment element based on health status; and (4) to the extent possible, include a risk adjustment element that takes into account functional status, socioeconomic status or cultural factors. The authority shall also consider methodologies to account for the following costs: (i) medical education; (ii) stand-by services and emergency services, including, but not limited to, trauma units and burn units; (iii) services provided by disproportionate share hospitals or other providers serving underserved populations; (iv) services provided to children; (v) research; (vi) care coordination and community based services provided by allied health professionals; (vii) the greater integration of behavioral and mental health; and (viii) the use and the continued advancement of new medical technologies, treatments, diagnostics or pharmacology products

that offer substantial clinical improvements and represent a higher cost than the use of current therapies.

Any best practices and standards developed under this section shall be shared with all private health plans for their voluntary adoption.

Section 10. (a) The authority, in consultation with the advisory board, shall administer the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of 2011. The fund shall be used for the following purposes: (1) to support the activities of the authority; and (2) to foster innovation in payment and health care service delivery.

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

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

(d) All approved activities funded through the Healthcare Payment Reform Fund shall support the commonwealth's efforts to meet the health care cost growth benchmark established under section 5, and shall include measurable outcomes in both cost reduction and quality improvement.

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

(f) Activities funded through the Healthcare Payment Reform Fund which demonstrates measurable success in improving care or reducing costs shall be shared with other providers, provider organizations and payers as model programs which may be voluntarily adopted by such other health care entities. The authority may also incorporate any successful models and practices into its standards for the Beacon ACO certification under section 8 and for alternative payment methodologies established for state-funded programs under section 9.

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

Section 11. (a) All expenses incurred in carrying out this chapter shall be payable solely from funds provided under the authority of this chapter and no liability or obligations shall be

incurred by the authority under this chapter beyond the extent to which monies shall have been provided under this chapter.

(b) The authority shall be liable on all claims made as a result of the activities, whether ministerial or discretionary, of any member, officer or employee of the authority acting as such, except for willful dishonesty or intentional violation of the law, in the same manner and to the same extent as a private person under like circumstances; provided, however, that the authority shall not be liable to levy or execution on any real or personal property to satisfy judgment, for interest prior to judgment, for punitive damages or for any amount in excess of $100,000.

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

(d) The authority may indemnify or reimburse any person, or a person's personal representative, for losses or expenses, including legal fees and costs, arising from any claim, action, proceeding, award, compromise, settlement or judgment resulting from such person's activities, whether ministerial or discretionary, as a member, officer or employee of the authority; provided, that the defense of settlement thereof shall have been made by counsel approved by the authority. The authority may procure insurance for itself and for its members,

officers and employees against liabilities, losses and expenses which may be incurred by virtue of this section or otherwise.

(e) No civil action under this chapter shall be brought more than 3 years after the date upon which the cause thereof accrued.

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

Section 12. The authority shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to its board, to the governor, to the general court and to the state auditor, such reports to be in a form prescribed by the board, with the written approval of the auditor. The board or the auditor may investigate the affairs of the authority, may severally examine the properties and records of the authority and may prescribe methods of accounting and the rendering of periodical reports in relation to projects undertaken by the authority. The authority shall be subject to biennial audit by the state auditor.

Section 13. The authority may adopt regulations to implement this chapter.

CHAPTER 176T

CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

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

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; an organization entering into a preferred provider arrangement under chapter 176I; a contributory group general or blanket insurance for persons in the service of the commonwealth under chapter 32A; a contributory group general or blanket insurance for persons in the service of counties, cities, towns and districts and their dependents under chapter 32B; the medical assistance program administered by the office of Medicaid under chapter 118E and under Title XIX of the Social Security Act or any successor statute; and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.

"Commissioner", the commissioner of insurance.

"Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.

"Nondiscriminatory basis", a carrier shall be providing coverage on a non-discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a physician assistant which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other participating providers.

"Participating provider', a provider who, under terms and conditions of a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to an insured with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly, from the carrier.

"Physician assistant", a person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician under sections 9C to 9H, inclusive, of chapter 112, and who has passed the Physician Assistant National Certifying Exam or its equivalent.

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

Section 2. The commissioner and the group insurance commission shall require that all carriers recognize physician assistants as participating providers subject to section 3 and shall include coverage on a nondiscriminatory basis to their insureds for care provided by physician assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a physician assistant who is a participating provider and is practicing within the scope of the physician assistant's professional authority as defined by statute, rule and physician delegation to the extent that such policy or

contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.

Section 3. A participating provider physician assistant practicing within the scope of the physician assistant's license, including all regulations requiring collaboration with or supervision by a physician under section 9E of chapter 112, shall be considered qualified within the carrier's definition of primary care provider to an insured.

Section 4. Notwithstanding any general or special law to the contrary, a carrier that requires the designation of a primary care provider shall provide its insured with an opportunity to select a participating provider physician assistant as a primary care provider.

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

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

SECTION 163. Clause (5) of subsection (d) of section 8A of chapter 180 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 100 and 101, the words "division of health care finance and policy pursuant to chapter 118G" and inserting in place thereof the following words:- institute of health care finance and policy under chapter 12C.

SECTION 164. Subsection (a) of section 9 of chapter 209C of the General Laws, as so appearing, is hereby amended by striking out, in lines 36 and 37, the words “the division of medical assistance or division of health care finance and policy” and inserting in place thereof the following words:- the office of Medicaid or the executive office of health and human services.

SECTION 165. Section 60K of chapter 231 of the General Laws, as so appearing, is hereby amended by striking out, in line 14, the figure “4” and inserting in place thereof the following figure:- 2.

SECTION 166. Said chapter 231 is hereby amended by inserting after section 60K, the following 3 sections:-

Section 60L. (a) Except as provided in this section, a person shall not commence an action against a provider of health care as defined in the seventh paragraph of section 60B unless the person has given the health care provider written notice under this section of not less than 182 days before the action is commenced.

(b) The notice of intent to file a claim required under subsection (a) shall be mailed to the last known professional business address or residential address of the health care provider who is the subject of the claim.

(c) The 182 day notice period in subsection (a) shall be shortened to 90 days if:

(1) the claimant has previously filed the 182 day notice required against another health care provider involved in the claim; or

(2) the claimant has filed a complaint and commenced an action alleging medical malpractice against 1 or more of the health care providers involved in the claim.

(d) The 182 day notice of intent required in subsection (a) shall not be required if the claimant did not identify and could not reasonably have identified a health care provider to which notice shall be sent as a potential party to the action before filing the complaint;

(e) The notice given to a health care provider under this section shall contain, but need not be limited to, a statement including:

(1) the factual basis for the claim;

(2) the applicable standard of care alleged by the claimant;

(3) the manner in which it is claimed that the applicable standard of care was breached by the health care provider;

(4) the alleged action that should have been taken to achieve compliance with the alleged standard of care;

(5) the manner in which it is alleged the breach of the standard of care was the proximate cause of the injury claimed in the notice; and

(6) the names of all health care providers that the claimant is notifying under this section in relation to a claim.

(f) Not later than 56 days after giving notice under this section, the claimant shall allow the health care provider receiving the notice access to all of the medical records related to the claim that are in the claimant's control and shall furnish release for any medical records related

to the claim that are not in the claimant's control, but of which the claimant has knowledge. This subsection shall not restrict a patient's right of access to the patient's medical records under any other law.

(g) Within 150 days after receipt of notice under this section, the health care provider or authorized representative against whom the claim is made shall furnish to the claimant or the claimant's authorized representative a written response that contains a statement including the following:

(1) the factual basis for the defense, if any, to the claim;

(2) the standard of care that the health care provider claims to be applicable to the action;

(3) the manner in which it is claimed by the health care provider that there was or was not compliance with the applicable standard of care; and

(4) the manner in which the health care provider contends that the alleged negligence of the health care provider was or was not a proximate cause of the claimant's alleged injury or alleged damage.

(h) If the claimant does not receive the written response required under subsection (g) within the required 150 day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 150 day time period. If a provider fails to respond within 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other means then interest on any judgment against that provider shall accrue and be calculated from the date that the notice was filed rather than the date that the suit is filed. At any time before the

expiration of the 150 day period, the claimant and the provider may agree to an extension of the 150 day period.

(i) If at any time during the applicable notice period under this section a health care provider receiving notice under this section informs the claimant in writing that the health care provider does not intend to settle the claim within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health care provider, so long as the claim is not barred by the statute of limitations or repose.

(j) A lawsuit against a health care provider filed within 6 months of the statute of limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any claimant, shall be exempt from compliance with this section.

(k) Nothing in this section shall prohibit the filing of suit at any time in order to seek court orders to preserve and permit inspection of tangible evidence.

Section 60M. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider licensed under section 2 of chapter 112, including actions under section 60B, an expert witness shall have been engaged in the practice of medicine at the time of the alleged wrongdoing.

Section 60N. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider licensed under section 2 of chapter 112, including actions under section 60B, an expert witness shall be board certified in the same specialty as the defendant physician as licensed under section 2 of chapter 112.

SECTION 167. Section 85K of said chapter 231, as appearing in the 2010 Official Edition, is hereby amended by inserting, in line 8, after the word “costs”, the following words:-

; provided, however, in the context of medical malpractice claims against a non-profit charity providing health care, such cause of action shall not exceed the sum of $100,000, exclusive of interest and costs.

SECTION 168. Chapter 233 of the General Laws is hereby amended by inserting after section 79K, the following new section:-

Section 79L. (a) As used in this section, the following words shall, unless the context clearly requires otherwise, have the following meanings:

“Facility”, a hospital, clinic, or nursing home licensed under chapter 111 or a home health agency; provided, that “facility” shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority or other entity comprised of such facilities.

“Health care provider”, any of the following health care professionals licensed under chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social worker, speech-language pathologist, audiologist, marriage and family therapist or mental health counselor; provided, that “health care provider” shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such health care providers.

“Unanticipated outcome”, the outcome of a medical treatment or procedure, whether or not resulting from an intentional act, that differs from an intended result of such medical treatment or procedure.

(b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error or a general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative proceeding, unless the maker of the statement, or a defense expert witness, when questioned under oath during the litigation about facts and opinions regarding any mistakes or errors that occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in which case the statements and opinions made about the mistake or error shall be admissible for all purposes. In situations where a patient suffers an unanticipated outcome with significant medical complication resulting from the provider’s mistake, the health care provider, facility or an employee or agent of a health care provider or facility shall fully inform the patient, and when appropriate the patient's family, about said unanticipated outcome.

SECTION 169. Clause (2) of subsection (b) of section 3 of chapter 258C of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out sub-clause (A) and inserting in place thereof the following sub-clause:- (A) Expenses incurred for hospital services as the direct result of injury to the victim shall be compensable under this chapter; provided, however, that when claiming compensation for hospital expenses, the claimant shall

demonstrate an out-of-pocket loss or a legal liability for payment of said expenses. No hospital expenses shall be paid if the expense is reimbursable by Medicaid or if the services are covered by chapter 118E. Every claim for compensation for hospital services shall include a certification by the hospital that the services are not reimbursable by Medicaid and that the services are not covered by chapter 118E. In no event shall the amounts awarded for hospital services exceed the rates for services established by the executive office of health and human services or a governmental unit designated by the executive office if rates have been established for such services.

SECTION 170. The second paragraph of section 4 of chapter 260 of the General Laws, as so appearing, is hereby amended by adding the following sentence:-

The statutes of limitation and repose in this paragraph shall be tolled for a period of 180 days when a notice of intent to file a claim, under subsection (a) of section 60L of chapter 231, is sent to a provider of health care as defined in the seventh paragraph of section 60B of chapter 231.

SECTION 171. Section 15 of chapter 305 of the acts of 2008 is hereby repealed.

SECTION 172. Chapter 288 of the acts of 2010 is hereby amended by striking out section 66 and inserting in place thereof the following section:-

SECTION 66. For small group base rate factors applied under section 3 of chapter 176J of the General Laws between October 1, 2010 and July 1, 2015, a carrier shall limit the effect of the application of any single or combination of rate adjustment factors identified in paragraphs (2) to (6), inclusive, of subsection (a) of said chapter 3 of said chapter 176J that are used in the calculation of an individual's or small group's premium so that the final annual premium charged

to an individual or small group does not increase by more than an amount established annually by the commissioner by regulation.

SECTION 173. Section 70 of said chapter 288 is hereby amended by striking out the figure “2012” and inserting in place thereof the following figure:- 2015.

SECTION 174. Notwithstanding any general or special law to the contrary, the commissioner of public health, in consultation with the board of registration in medicine, shall promulgate regulations on or before April 1, 2013 to enforce section 226 of chapter 111 of the General Laws.

SECTION 175. Notwithstanding any general or special law to the contrary, the department of public health, in consultation with the division of insurance, shall examine and study best practices and successful models of private sector wellness and health management programs in order to create a model wellness guide for payers, employers and consumers. The department shall also issue a report that identifies those elements of said programs that should be promoted in support of the state’s efforts to meet the health care cost growth benchmark established under section 5 of chapter 176S.

The model guide shall provide the following information: (i) the importance of healthy lifestyles, disease prevention, care management and health promotion programs; (ii) financial and other incentives for brokers, payers and consumers to encourage health and wellness program offerings for consumers and to expand options for individuals who do not have access to these programs through their workplace; (iii) benefit designs that tie financial consequences to health care choices; (iv) use of technology to provide wellness information and services; and (v)

identifying qualitative and quantitative program measures to place real value on program results and track program effectiveness.

In developing the report and model guide, the secretary shall consult with health care stakeholders, including but not limited to: employers, including representatives of employers with more than 50 employees and representatives of employers with less than 50 employees; providers and provider organizations; health carriers; and consumers. The report, along with any recommendations, shall be submitted to the joint committee on health care financing, the house and senate committees on ways and means and the secretary of health and human services by January 1, 2013. The recommendations shall assist in the development of strategies and programs supported by the Prevention and Wellness Trust Fund established under section 2G of chapter 111 of the General Laws.

SECTION 176. Notwithstanding any general or special law or rule or regulation to the contrary, the commissioner of insurance shall promulgate regulations requiring any carrier, as defined in section 1 of chapter 176O of the General Laws, and their contractors to comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008, section 511 of Public Law 110-343. The commissioner of insurance shall promulgate said regulations not later than January 1, 2013. The regulations shall be implemented as part of any provider contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed or amended on or after July 31, 2012.

Starting on July 1, 2013, the commissioner of insurance shall require all carriers and their contractors, to submit an annual report to the division of insurance, which shall be a public record, certifying and outlining how their health benefit plans are in compliance with the federal

Mental Health Parity and Addiction Equity Act and this section. The division of insurance shall forward all such reports to the attorney general for verification of compliance with the federal Mental Health Parity and Addiction Equity Act and this section.

SECTION 177. Notwithstanding any general or special law or rule or regulation to the contrary, the office of Medicaid shall promulgate regulations requiring any Medicaid health plan and managed care organization and their health plans and any behavioral health management firm and third party administrator under contract with a Medicaid managed care organization to comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008, section 511 of Public Law 110-343. The office of Medicaid shall promulgate said regulations not later than January 1, 2013. The regulations shall be implemented as part of any provider contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed or amended on or July 31, 2012.

Starting on July 1, 2013, the office of Medicaid shall submit an annual report to the house and senate chairs of the joint committee on health care financing, the house and senate chairs of the joint committee on mental health and substance abuse, the clerk of the senate and the clerk of the house of representatives certifying and outlining how the health benefit plans under the office of Medicaid, and any contractors, are in compliance with the federal Mental Health Parity and Addiction Equity Act and this section. The office of Medicaid shall forward all such reports to the department of the attorney general for verification of compliance with the federal Mental Health Parity and Addiction Equity Act and this section.

SECTION 178. Notwithstanding any general or special law to the contrary, the board of registration of medicine, established under section 10 of chapter 13 of the General Laws, shall

promulgate regulations relative to the education and training of health care providers in the early disclosure of adverse events, including, but not limited to, continuing medical education requirements. Nothing in this section shall affect the total hours of continuing medical education required by the board, including the number of hours required relative to risk management.

SECTION 179. Notwithstanding any general or special law to the contrary, the department of public health, in consultation with the Betsy Lehman center for patient safety and medical error reduction, established under section 16E of chapter 6A of the General Laws, shall create an independent task force to study and reduce the practice of defensive medicine and medical overutilization in the commonwealth, including but not limited to the overuse of imaging and screening technologies. At least 1 member of the task force shall be a health care consumer representative. The task force shall issue a report on the financial and non-financial impacts of defensive medicine and the impact of overutilization on patient safety. The task force shall file a report of its study, including its recommendations and drafts of any legislation, if necessary, by filing the same with the clerks of the senate and house of representatives who shall forward a copy of the report to the joint committee on public health and the joint committee on health care financing within 1 year of the effective date of this act.

SECTION 180. Notwithstanding any general or special law to the contrary, to the extent that the office of Medicaid, the group insurance commission, the commonwealth health insurance connector authority and any other state funded insurance program determine that accountable care organizations offer opportunities for cost-effective and high quality care, such state funded insurance programs shall prioritize provider organizations which have been certified by the board of the health care quality and finance authority as Beacon ACOs, under section 8 of chapter 176S, for the delivery of publicly funded health services.

SECTION 181. Any provider organization that entered a network contract prior to the effective date of chapter 12C of the General Laws, which organization receives, or represents providers who collectively receive, at least $10,000,000 in annual net patient service revenue from carriers or third-party administrators or which has entered full-risk contracts or which is corporately affiliated with a carrier, shall register under section 10 of said chapter 12C not later than December 1, 2012. Any other provider organization that entered a network contract prior to the effective date of said chapter 12C and is required under said section 10 of said chapter 12C to register shall register not later than December 1, 2013.

Notwithstanding any other provision of said chapter 12C, and as a condition of licensure under chapter 111 of the General Laws, any provider that is part of or represented by a provider organization that entered a network contract and fails to register under said section 10 of said chapter 12C shall continue to deliver care under such network contract for the duration of such contract, or a period of 5 years, whichever is longer, at the contract terms and payment levels in effect upon the date the provider organization fails to register under said section 10 of said chapter 12C.

SECTION 182. There shall be a task force comprised of 9 representatives with expertise in behavioral health treatment, service delivery, integration of behavioral health with primary care and behavioral health reimbursement systems. The health care quality and finance authority shall appoint the members of the task force. The task force shall report to the authority its findings and recommendations relative to: (i) the most effective and appropriate approach to including behavioral health services in the array of services provided by integrated provider organizations; (ii) how current prevailing reimbursement methods and covered behavioral health benefits may need to be modified to achieve more cost effective, integrated and high quality

behavioral health outcomes; and (iii) the extent to which and how payment for behavioral health services should be included under alternative payment methods. The task force shall submit its report of findings and recommendations to the authority not later than July1, 2013.

SECTION 183. Notwithstanding any general or special law to the contrary, the department of public health shall submit a health resource plan to the governor and the general court, as required by section 25A of chapter 111 of the General Laws, not later than January 1, 2014.

SECTION 184. Notwithstanding any general or special law to the contrary, there shall be a special task force, to study issues related to the accuracy of medical diagnosis in the commonwealth, called the Massachusetts Diagnostic Accuracy Task Force. The task force shall investigate and report on: the extent to which diagnoses in the commonwealth are accurate and reliable; the underlying systematic causes of inaccurate diagnosis; estimation of the financial cost to the state, insurers and employers of inaccurate diagnoses; the negative impact on patients caused by inaccurate diagnoses; and recommendations to reduce or eliminate the impact of inaccurate diagnoses.

The Massachusetts Diagnostic Accuracy Task Force shall be comprised of 9 members, including the commissioner of public health, or a designee, who shall act as the chair; and 8 members, who shall be appointed by the commissioner of public health, who shall reflect a broad distribution of diverse perspectives on the health care system, including health care professionals, consumer representatives, provider organizations and payers.

The task force shall file a report of its study, including its recommendations and drafts of any legislation, if necessary, with the clerks of the senate and house of representatives within 1 year of the effective date of this act.

SECTION 185. Notwithstanding any general or special law to the contrary, the institute of health care finance and policy shall, in consultation with the executive office of health and human services, the department of public health, the office of Medicaid and the division of insurance, review existing reporting and data collection requirements for health care providers, provider organizations and payers. The institute shall identify reporting and data collection requirements that are unnecessary, duplicative, which could be combined or which should be transferred to the institute in its role as the primary health care data repository for the commonwealth.

The institute shall file the results of its review, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than January 1, 2014.

SECTION 186. Notwithstanding any general or special law to the contrary, beginning not later than July 1, 2014, the group insurance commission, MassHealth and any other state funded insurance program shall, to the maximum extent feasible, implement alternative payment methodologies, as defined in section 1 of chapter 12C. The alternative payment methodologies shall be developed in consultation with the health care quality and finance authority under

section 8 of chapter 176S and all affected publically funded health plans, including, but not limited to, the Medicaid managed care organizations.

SECTION 187. Notwithstanding any general or special law to the contrary, the health care quality and finance authority shall contract with an independent outside organization to conduct a comprehensive review of the impact of this act, and transformations in the health care payment system and care delivery system in the commonwealth, on health care consumers, the health care workforce and the general public.

The review shall include, but not be limited to, an investigation of:

(1) The impact on health care costs, including the extent to which savings have reduced out-of-pocket costs to individuals and families, health insurance premium costs and health care costs borne by the commonwealth;

(2) The impact on access to health care services and quality of care in different regions and for different populations, particularly for children, the elderly, low-income individuals, individuals with disabilities and other vulnerable populations;

(3) The impact on access and quality of care for specific services, particularly primary care, behavioral and mental health services;

(4) The impact on the health care workforce, including, but not limited to, health care worker recruitment and retention, health care worker shortages, training and education requirements and job satisfaction; and

(5) The impact on public health, including, but not limited to, reducing the prevalence of preventable health conditions, improving employee wellness and reducing racial and ethnic disparities in health outcomes.

The organization shall, to the extent possible, obtain and use data from the institute of health care finance and policy to conduct its analysis; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

The health care quality and finance authority shall report the results of such review and its recommendations, if any, together with drafts of legislation necessary to carry out such recommendations to the house and senate committees on ways and means, the joint committee on public health and post the results on the health care quality and finance authority's website not later than March 31, 2017.

SECTION 188. Notwithstanding any general or special law or rule or regulation to the contrary, upon the adoption of national electronic prior authorization standards by the National Council for Prescription Drug Programs, the e-Health Institute shall prepare a report that identifies the appropriate administrative regulations of the commonwealth that will need to be promulgated in order to make those standards effective within 12 months of adoption of said standards by the National Council for Prescription Drug Programs. The institute shall, not later than 6 months after the adoption of such standards by the National Council for Prescription Drug Programs, submit its report together with any further recommendations and draft legislative language necessary to carry out its recommendations to the joint committee on public health, the joint committee on health care financing and the governor.

SECTION 189. There shall be a special commission to review public payer reimbursement rates and payment systems for health care services and the impact of such rates and payment systems on health care providers and on health insurance premiums in the commonwealth. The commission shall consist of 11 members: 1 of whom shall be the secretary of health and human services or a designee, who shall serve as chair; 1 of whom shall be the director of the office of Medicaid; 1 of whom shall be the executive director of the institute of health care finance and policy; 1 of whom shall be appointed by the Massachusetts Hospital Association; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed by the Home Care Alliance of Massachusetts; 1 of whom shall be appointed by the Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the Massachusetts Association for Behavioral Healthcare; and 2 of whom shall be appointed by the governor, 1 of whom shall be represent managed care organizations contracting with MassHealth and 1 of whom shall be an expert in medical payment methodologies from a foundation or academic institution.

The commission shall examine whether public payer rates and rate methodologies provide fair compensation for health care services and promote high-quality, safe, effective, timely, efficient, culturally competent and patient-centered care. The commission's analysis shall include, but not be limited to, an examination of MassHealth rates and rate methodologies; current and projected federal financing, including Medicare rates; cost-shifting and the interplay between public payer reimbursement rates and health insurance premiums; and the degree to which public payer rates reflect the actual cost of care.

To conduct its review and analysis, the commission may contract with an outside organization with expertise in the analysis of health care financing. The institute of health care finance and policy and the office of Medicaid shall provide the outside organization, to the extent possible, with any relevant data necessary for the evaluation; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than April 1, 2013.

SECTION 190. There shall be a special commission to review variation in prices among providers. The commission shall consist of 14 members: 1 of whom shall be the executive director of the institute of health care finance and policy or a designee, who shall serve as chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of whom shall be the executive director of the group insurance commission or a designee; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the attorney general or a designee; 4 of whom shall be appointed by the governor, 1 of whom shall be a health economist, 1 of whom shall have expertise in the area of health care payment methodology, 1 of whom shall represent non-physician health care providers and 1 of whom shall represent an academic medical center or teaching hospital; 1 of whom shall be appointed by the senate president and shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be appointed by the speaker of the house of representatives and

shall be a health economist or have expertise in the area of health care payment methodology; 1 of whom shall be a representative of the Massachusetts Association of Health Plans, Inc.; 1 of whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall be a representative of the Massachusetts Medical Society.

The commission shall conduct a rigorous analysis to identify the acceptable and unacceptable factors contributing to price variation in physician, hospitals, diagnostic testing and ancillary services. The analysis shall include, but not be limited to, an examination of the following factors: quality, medical education, stand-by service capacity, emergency service capacity, special services provided by disproportionate share hospitals and other providers serving underserved or unique populations, market share, advertising, location, research, costs, care coordination, community-based services provided by allied health professionals and use of and continued advancement of medical technology and pharmacology. The analysis shall also include a comparison of price variation between providers in the commonwealth and providers in other states.

After identifying such factors, the commission shall recommend steps to reduce provider price variation and shall recommend the maximum reasonable adjustment to a commercial insurer's median rate for individual or groupings of services for each acceptable factor.

To conduct its review and analysis, the commission may contract with an outside organization with expertise in the analysis of health care financing and provider payment methodologies. The institute of health care finance and policy shall provide the commission and any contracted outside organization, to the extent possible, relevant data necessary for the

evaluation; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

The commission shall file the results of its study, together with drafts of legislation, if any, necessary to carry out its recommendations, by filing the same with the clerks of the house of representatives and the senate who shall forward a copy of the study to the house and senate committees on ways and means and the joint committee on health care financing not later than January 1, 2014.

SECTION 191. (a) There shall be an e-Health commission which shall evaluate the effectiveness of expenditures authorized under section 6D of chapter 40J of the General Laws. The commission shall consist of 17 members: 1 of whom shall be the secretary of administration and finance or a designee, who shall serve as chair; 1 of whom shall be the secretary of health and human services or a designee; 1 of whom shall be the executive director of the institute of health care finance and policy or a designee; 1 of whom shall be the secretary of housing and economic development or a designee; 1 of whom shall be the senate chair of the joint committee on health care financing; 1 of whom shall be the house chair of the joint committee on health care financing; 11 of whom shall be appointed by the governor, 1 of whom shall be an expert in health information technology, 1 of whom shall be an expert in state and federal health privacy laws, 1 of whom shall be an expert in health policy, 1 of whom shall be an expert in health information technology relative to privacy and security, 1 of whom shall be from an academic medical center, 1 of whom shall be from a community hospital, 1 of whom shall be from a community health center, 1 of whom shall be from a long term care facility, 1 of whom shall be from a physician group practice and 2 of whom shall represent health insurance carriers.

(b) The commission shall review the Massachusetts e-Health Institute, including an analysis of all relevant data so as to determine the effectiveness and return on investment of funding under said section 6D of said chapter 40J. The report shall include specific legislative recommendations including the following:-

(1) to what extent the program increased the adoption of interoperable electronic health records, including to what extent the program increased the adoption of interoperable electronic health records for providers;

(2) to what extent the program reduced health care costs or the growth in health care cost trends on a provider-based net cost and health plan based premium basis, including an analysis of what entities benefitted or were disadvantaged from any cost reductions and the specific impact of the funding mechanism as established in subsection (a) of section 70 of chapter 118E;

(3) to what extent the program increased the number of health care providers in achieving and maintaining compliance with the standards for meaningful use, beyond stage 1, established by the United States Department of Health and Human Services ;

(4) to what extent the program should be discontinued, amended or expanded, and if so, a timetable for implementation of the recommendations; and

(5) to what extent additional public funding is needed for the e-Health Institute Fund, as established in section 6E of chapter 40J of the General Laws.

(c) To conduct these studies, the commission shall contract with an outside organization with expertise in the analysis of the health care financing. In conducting its examination, the

outside organization shall, to the extent possible, obtain and use actual health plan data from the all-payer claims database as administered by the institute of health care finance and policy; but such data shall be confidential and shall not be a public record for any purpose.

(d) The commission shall report the results of its investigation and study and its recommendations, if any, together with drafts of legislation necessary to carry out such recommendations by March 31, 2017. The report shall be provided to the chairs of the house and senate ways and means committees and the joint committee on health care financing and shall be posted on the department's website.

SECTION 192. (a) There shall be a commission on prevention and wellness which shall evaluate the effectiveness of the program authorized under section 2G of chapter 111 of the General Laws. The commission shall consist of 19 members: 1 of whom shall be the commissioner of public health or a designee, who shall serve as the chair; 1 of whom shall be the executive director of the institute of health care finance and policy established in chapter 12C or a designee; 1 of whom shall be the secretary of health and human services or a designee; 2 of whom shall be the house and senate chairs of the joint committee on public health; 2 of whom shall be the house and senate chairs of the joint committee on health care financing; and 12 of whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field of public health economics, 1 of whom shall be a person with expertise in public health research, 1 of whom shall be a person with expertise in the field of health equity, 1 of whom shall be a person from a local board of health for a city or town with a population greater than 50,000, 1 of whom shall be a person of a board of health for a city or town with a population less than 50,000, 2 of whom shall be representatives of health insurance carriers, 1 of whom shall be a person from a consumer health organization, 1 of whom shall be a person from a hospital association, 1 of

whom shall be a person from a statewide public health organization, 1 of whom shall be a representative of the interest of businesses, and 1 of whom shall be a person from an association representing community health workers.

(b) The commission shall review the program authorized under said section 2G of said chapter 111 and shall issue a report. The report shall include an analysis of all relevant data to determine the effectiveness and return on investment of the program including, but not limited to, an analysis of: (i) the extent to which the program impacted the prevalence of preventable health conditions; (ii) the extent to which the program reduced health care costs or the growth in health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the reduction; (iv) the extent to which workplace-based wellness or health management programs were expanded, and whether those programs improved employee health, productivity and recidivism; (v) if employee health and productivity was improved or employee recidivism was reduced, the estimated statewide financial benefit to employers; (vi) recommendations for whether the program should be discontinued, amended or expanded, as well as a timetable for implementation of the recommendations; and (vii) the extent to which additional funding is needed for the Prevention and Wellness Trust Fund, as established in said section 2G of said chapter 111, and a recommendation for a funding mechanism beyond 2017.

(c) To conduct its evaluation, the commission shall contract with an outside organization with expertise in the analysis of health care financing. In conducting its evaluation, the outside organization shall, to the extent possible, obtain and use actual health plan data from the all-payer claims database as administered by the institute of health care finance and policy; provided, however, that such data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

(d) The commission shall report the results of its investigation and study and its recommendation, if any, together with drafts of legislation necessary to carry out such recommendation to the house and senate committees on ways and means, the joint committee on public health and shall be posted on the department's website not later than March 31, 2017.

SECTION 193. (a) Notwithstanding any general or special law to the contrary, this section shall facilitate the orderly transfer of employees, proceedings, rules and regulations, property and legal obligations of the following functions of state government from the transferor agency to the transferee agency, defined as follows:

(1) the functions of the division of health care finance and policy, as the transferor agency, to the institute of health care finance and policy, as the transferee agency; provided however, that this section shall not apply to the functions of the division of health care finance and policy that relate to the administration of the health safety net fund;

(2) the functions of the division of health care finance and policy related to the administration of the health safety net fund, as the transferor agency, to the office of Medicaid, as the transferee agency;

(3) the functions of the health care quality and cost council, as the transferor agency, to the institute of health care finance and policy, as the transferee agency.

(b) To the extent that employees of the transferor agency, including those who were appointed immediately before the effective date of this act and who hold permanent appointment in positions classified under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are transferred to the respective transferee agency, such transfers shall be

effected without interruption of service within the meaning of said section 9A of said chapter 31, without impairment of seniority, retirement or other rights of the employee, and without reduction in compensation or salary grade, notwithstanding any change in title or duties resulting from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and benefits, and without change in union representation or certified collective bargaining unit as certified by the state division of labor relations or in local union representation or affiliation. Any collective bargaining agreement in effect immediately before the transfer date shall continue in effect and the terms and conditions of employment therein shall continue as if the employees had not been so transferred. The reorganization shall not impair the civil service status of any such reassigned employee who immediately before the effective date of this act either holds a permanent appointment in a position classified under chapter 31 of the General Laws or has tenure in a position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding any other general or special law to the contrary, all such employees shall continue to retain their right to collectively bargain pursuant to chapter 150E of the General Laws and shall be considered employees for the purposes of said chapter 150E. Nothing in this section shall be construed to confer upon any employee any right not held immediately before the date of said transfer, or to prohibit any reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or abolition of position not prohibited before such date.

(c) All petitions, requests, investigations and other proceedings appropriately and duly brought before the transferor agency or duly begun by the transferor agency and pending before it before the effective date of this act, shall continue unabated and remain in force, but shall be assumed and completed by the transferee agency.

(d) All orders, rules and regulations duly made and all approvals duly granted by the transferor agency, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency.

(e) All books, papers, records, documents, equipment, buildings, facilities, cash and other property, both personal and real, including all such property held in trust, which immediately before the effective date of this act are in the custody of the transferor agency shall be transferred to the transferee agency.

(f) All duly existing contracts, leases and obligations of the transferor agency shall continue in effect but shall be assumed by the transferee agency. No existing right or remedy of any character shall be lost, impaired or affected by this act.

SECTION 194. Notwithstanding any general or special law to the contrary, the commissioner of health care finance and policy as of the effective date of this act shall, with the approval of the governor, become the interim executive director of the institute of health care finance and policy on the effective date of this act. The interim executive director shall serve at the pleasure of the governor, and may be removed by the governor at any time. If there is a vacancy in the office of the interim executive director before January 1, 2014, the executive director of the institute of health care finance and policy shall be appointed by a majority vote of the governor, the auditor and the attorney general as required under section 2 of chapter 12C of the General Laws.

Beginning on January 1, 2014, the executive director of the institute of health care finance and policy shall be appointed by a majority vote of the governor, the auditor and the attorney general as required under section 2 of chapter 12C of the General Laws.

SECTION 195. Notwithstanding any general or special law or rule or regulation to the contrary, all orders, rules and regulations duly made and all approvals duly granted by the transferor agency, the division of health care finance and policy, in relation to sections 2A, 6B, 7, 9 to 15, 17, 25 and 28 to 39 of chapter 118G of the General Laws, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency, the executive office of health and human services.

SECTION 196. Notwithstanding any general or special law or rule or regulation to the contrary, all orders, rules and regulations duly made and all approvals duly granted by the transferor agency, the division of health care finance and policy, in relation to section 18 of chapter 15A, sections 6C and 18B of chapter 118G and section 188 of chapter 149 of the General Laws, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency, the commonwealth health insurance connector.

SECTION 197. Notwithstanding any general or special law or rule or regulation to the contrary, all orders, rules and regulations duly made and all approvals duly granted by the transferor agency, the division of health care finance and policy, in relation to sections 5, 6, 6A, 6½, 8, 16 and 23 of chapter 118G of the General Laws, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until

superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency, the institute of health care finance and policy.

SECTION 198. Notwithstanding any general or special law or rule or regulation to the contrary, all orders, rules and regulations duly made and all approvals duly granted by the transferor agency, the division of health care finance and policy, in relation to section 41 chapter 118G of the General Laws, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency, the department of public health.

SECTION 199. The division of insurance shall develop prior authorization forms under section 24 of chapter 176O of the General Laws not later than July 1, 2013.

SECTION 200. Section 87 shall take effect on January 1, 2015.

SECTION 201. Section 70 of chapter 118E of the General Laws shall take effect on July 1, 2012.

SECTION 202. Section 70 of chapter 118E of the General Laws is hereby repealed.

SECTION 203. Sections 144 and 147 shall take effect on July 1, 2013.

SECTION 204. Sections 191 and 192 shall take effect on July 1, 2016.

SECTION 205. Section 202 shall take effect on July 1, 2017.