

SENATE No. 02400

The Commonwealth of Massachusetts

SENATE, July 30, 2012

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

For the committee,

RICHARD T. MOORE.

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

45 Section 16T.(a) There shall be a health planning council within the executive office of
46 health and human services, consisting of the secretary of health and human services or a designee
47 who shall serve as chair, the commissioner of public health or a designee, the director of the
48 office of Medicaid or a designee, the commissioner of mental health or a designee, the secretary
49 of elder affairs or a designee, the executive director of the center for health information and
50 analysis or a designee, the executive director of the health policy commission or a designee and 3
51 members appointed by the governor, of whom shall be a health economist; 1 of whom shall have
52 experience in health policy and planning and 1 of whom shall have experience in health care
53 market planning and service line analysis.

54 The council shall assemble an advisory committee of not more than 13 members who
55 shall reflect a broad distribution of diverse perspectives on the health care system, including

56 health care providers and provider organizations, third-party payers, both public and private,
57 consumer representatives and labor organizations representing health care workers. The advisory
58 committee shall review drafts and provide recommendations to the council during the
59 development of the plan.

60 The executive office of health and human services, with the council, shall conduct at least
61 5 public hearings, in geographically diverse areas, on the plan as proposed and shall give
62 interested persons an opportunity to submit their views orally and in writing. In addition, the
63 executive office may create and maintain a website to allow members of the public to submit
64 comments electronically and review comments submitted by others. The state health plan shall
65 identify needs of the commonwealth in health care services, providers, programs and facilities;
66 the resources available to meet those needs; and the priorities for addressing those needs.

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

76 The plan shall identify certain categories of health care resources, including acute care
77 units; non-acute care units; specialty care units, including, but not limited to, burn, coronary care,

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

88 The plan shall also make recommendations for the appropriate supply and distribution of
89 resources, programs, capacities, technologies and services identified in the second paragraph of
90 this subsection on a state-wide or regional basis based on an assessment of need for the next 5
91 years and options for implementing such recommendations. The recommendations shall reflect at
92 least the following goals: to maintain and improve the quality of health care services; to support
93 the state's efforts to meet the health care cost growth benchmark established under section 9 of
94 chapter 6D; to support innovative health care delivery and alternative payment models as
95 identified by the commission; to reduce unnecessary duplication; to support universal access to
96 community-based preventative and patient-centered primary health care; to reduce health
97 disparities; to support efforts to integrate mental health, behavioral and substance use disorder
98 services with overall medical care; to reflect the latest trends in utilization and support the best
99 standards of care; and to rationally distribute health care resources across geographic regions of

100 state based on the needs of the population on a statewide basis, as well as, the needs of particular
101 geographic areas of the state.

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

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

114 The inventory compiled under subsection (b) and all related information shall be
115 maintained in a form usable by the general public in a designated office of the department, shall
116 constitute a public record and shall be coordinated with information collected by the department
117 under other laws, federal census information and other vital statistics from reliable sources;
118 provided, however, that any item of information which is confidential or privileged in nature or
119 under any other law shall not be regarded as a public record under this section.

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

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

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

132 CHAPTER 6D

133 HEALTH POLICY COMMISSION

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

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

139 “Acute hospital”, the teaching hospital of the University of Massachusetts Medical
140 School and any hospital licensed under section 51 of chapter 111 and which contains a majority

141 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of
142 public health.

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

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

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

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

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

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

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

160 “Carrier”, an insurer licensed or otherwise authorized to transact accident or health
161 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter

162 176A; a nonprofit medical service corporation organized under chapter 176B; a health
163 maintenance organization organized under chapter 176G; and an organization entering into a
164 preferred provider arrangement under chapter 176I; provided, that this shall not include an
165 employer purchasing coverage or acting on behalf of its employees or the employees of 1 or
166 more subsidiaries or affiliated corporations of the employer; provided that, unless otherwise
167 noted, the term “carrier” shall not include any entity to the extent it offers a policy, certificate or
168 contract that provides coverage solely for dental care services or visions care services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

240 “Health status adjusted total medical expenses”, the total cost of care for the patient
241 population associated with a provider group based on allowed claims for all categories of
242 medical expenses and all non-claims related payments to providers, adjusted by health status,
243 and expressed on a per member per month basis, as calculated under section 8 of chapter 12C.

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

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

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

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

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

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

259 “Net cost of private health insurance”, the difference between health premiums earned
260 and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as
261 included in medical loss ratio regulations promulgated by the division of insurance; (ii) net
262 additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise
263 defined by regulations promulgated by the center under chapter 12C.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

306 independent practice associations, provider networks, accountable care organizations and any
307 other organization that contracts with carriers for payment for health care services.

308 “Public health care payer”, the Medicaid program established in chapter 118E; any
309 carrier or other entity that contracts with the office of Medicaid or the commonwealth health
310 insurance connector to pay for or arrange the purchase of health care services on behalf of
311 individuals enrolled in health coverage programs under Titles XIX or XXI, or under the
312 commonwealth care health insurance program, including prepaid health plans subject to section
313 28 of chapter 47 of the acts of 1997; the group insurance commission established under chapter
314 32A; and any city or town with a population of more than 60,000 that has adopted chapter 32B.

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

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

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

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

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

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

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

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

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

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

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

347 “Surcharge payor”, an individual or entity that pays for or arranges for the purchase of
348 health care services provided by acute hospitals and ambulatory surgical center services provided

349 by ambulatory surgical centers; provided, however, that the term “surcharge payor” shall include
350 a managed care organization; and provided further, that “surcharge payor” shall not include Title
351 XVIII and Title XIX programs and their beneficiaries or recipients, other governmental
352 programs of public assistance and their beneficiaries or recipients and the workers’ compensation
353 program established under chapter 152.

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

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

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

365 Section 2. (a) There shall be established within the executive office for administration
366 and finance, but not under its control, a state agency known as the health policy commission.
367 The commission shall be an independent public entity not subject to the supervision and control
368 of any other executive office, department, commission, board, bureau, agency or political
369 subdivision of the commonwealth.

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

382 The person appointed by the governor to serve as chairperson shall have demonstrated
383 expertise in health care delivery, health care management at a senior level or health care finance
384 and administration, including payment methodologies. The initial appointment of the
385 chairperson shall be for a term of 3 years; provided, however, that subsequent appointments shall
386 be for a term of 5 years. The second person appointed by the governor, shall have demonstrated
387 expertise in health plan administration and finance and shall be initially appointed for a term of 4
388 years. The third person appointed by the governor, shall be a primary care physician and shall be
389 initially appointed for a term of 5 years. Of those persons appointed by the attorney general,
390 1 shall have demonstrated expertise in health care consumer advocacy and shall be initially
391 appointed for a term of 2 years; 1 shall be a health economist and shall be initially appointed for
392 a term of 3 years; and 1 shall have expertise in behavioral health, substance use disorder, mental

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

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

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

416 subject to section 42 of chapter 30 and section 10 of chapter 66. All moneys of the commission
417 shall be considered to be public funds for purposes of chapter 12A. Except as otherwise provided
418 in this section, the operations of the commission shall be subject to chapter 268A and chapter
419 268B.

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

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

431 The executive director shall not be required to obtain the approval of any other executive
432 agency in connection with appointment of employees. Sections 9A, 45, 46 and 46C of chapter
433 30, chapter 31 and chapter 150E shall not apply to the executive director of the commission.
434 Sections 45, 46 and 46C of chapter 30 shall not apply to any employee of the commission. The
435 executive director may establish personnel regulations for the officers and employees of the
436 commission.

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

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

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

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

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

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

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

452 The board may approve the use of funds from the Healthcare Payment Reform Fund to
453 support the annual budget of the commission, in addition to funds from any other source and any
454 funds appropriated therefor by the general court. The commission shall not be required to obtain
455 the approval of any other executive agency in connection with the development and
456 administration of its annual budget.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

494 (k) to establish lines of credit, and establish 1 or more cash and investment accounts to
495 receive payments for services rendered, appropriations from the commonwealth and for all other
496 business activity granted by this chapter except to the extent otherwise limited by any applicable
497 provision of the Employee Retirement Income Security Act of 1974; and

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

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

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

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

517 The assessed amount for hospitals and ambulatory surgical centers shall be not less than
518 33 per cent of the amount appropriated by the general court for the expenses of the commission
519 minus amounts collected from: (i) filing fees; (ii) fees and charges generated by the commission;

520 and (iii) federal matching revenues received for these expenses or received retroactively for
521 expenses of predecessor agencies. Each acute hospital and ambulatory surgical center shall pay
522 such assessed amount multiplied by the ratio of the hospital's or ambulatory surgical center's
523 gross patient service revenues to the total of all such hospital's and ambulatory surgical center's
524 gross patient services revenues. Each acute hospital and ambulatory surgical center shall make a
525 preliminary payment to the commission on October 1 of each year in an amount equal to ½ of
526 the previous year's total assessment. Thereafter, each hospital and ambulatory surgical center
527 shall pay, within 30 days notice from the commission, the balance of the total assessment for the
528 current year based upon its most current projected gross patient service revenue. The commission
529 shall subsequently adjust the assessment for any variation in actual and estimated expenses of the
530 commission and for changes in hospital or ambulatory surgical center gross patient service
531 revenue. Such estimated and actual expenses shall include an amount equal to the cost of fringe
532 benefits and indirect expenses, as established by the comptroller under section 5D of chapter 29.
533 In the event of late payment by any such hospital or ambulatory surgical center, the treasurer
534 shall advance the amount of due and unpaid funds to the commission prior to the receipt of such
535 monies in anticipation of such revenues up to the amount authorized in the then current budget
536 attributable to such assessments and the commission shall reimburse the treasurer for such
537 advances upon receipt of such revenues. This section shall not apply to any state institution or to
538 any acute hospital which is operated by a city or town.

539 The assessed amount for surcharge payors shall be not less than 33 per cent of the amount
540 appropriated by the general court for the expenses of the commission minus amounts collected
541 from (i) filing fees; (ii) fees and charges generated by the commission's publication or
542 dissemination of reports and information; and (iii) federal matching revenues received for these

543 expenses or received retroactively for expenses of predecessor agencies. The assessment on
544 surcharge payors shall be calculated and collected in the same manner as the assessment
545 authorized under section 68 of chapter 118E.

546 Section 7. (a) The commission, in consultation with the advisory council, shall administer
547 the Healthcare Payment Reform Fund, established under section 100 of chapter 194 of the acts of
548 2011. The fund shall be used for the following purposes: (1) to support the activities of the
549 commission; and (2) to foster innovation in health care payment and service delivery.

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

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

560 (d) The commission shall consider proposals that achieve 1 or more of the following
561 goals: (i) to support safety-net provider and disproportionate share hospital participation in new
562 payment and health care payment and service delivery models; (ii) to support the successful
563 implementation of performance improvement plans by health care entities under subsection (c)
564 of section 10; (iii) to support cooperative efforts between representatives of employees and

565 management that are focused on controlling costs and improving the quality of care through
566 workforce engagement; (iv) to support the evaluation of mobile health and connected health
567 technologies to improve health outcomes among under-served patients with chronic diseases; (v)
568 to develop the capacity to safely and effectively treat chronic, common and complex diseases in
569 rural and underserved areas and to monitor outcomes of those treatments; and (vi) any other
570 goals as determined by the commission.

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

575 (f) To the maximum extent feasible, the commission shall seek to coordinate
576 expenditures from the Healthcare Payment Reform Fund with other public expenditures from the
577 Prevention and Wellness Trust Fund, the E-Health Institute Fund, the Massachusetts Health
578 Information Exchange Fund, the Distressed Hospital Trust Fund, the Health Care Workforce
579 Transformation Trust Fund, the executive office of health and human services, any funding
580 available through the Medicare program and the CMS Innovation Center, established under the
581 federal Patient Protection and Affordable Care Act and any funding expended under the Delivery
582 System Transformation Initiative Master Plan and hospital-specific plans approved in the
583 MassHealth section 1115 demonstration waiver.

584 (g) Activities funded through the Healthcare Payment Reform Fund that demonstrate
585 measurable success in improving care or reducing costs shall be shared with other providers,
586 provider organizations and payers as model programs which may be voluntarily adopted by such

587 other health care entities. The commission may also incorporate any successful models and
588 practices into its standards for ACO certification under section 15 and for alternative payment
589 methodologies established for state-funded programs.

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

598 Section 8. (a) Not later than October 1 of every year, the commission shall hold public hearings
599 based on the report submitted by the center for health information and analysis under section 16
600 of chapter 12C comparing the growth in total health care expenditures to the health care cost
601 growth benchmark for the previous calendar year. The hearings shall examine health care
602 provider, provider organization and private and public health care payer costs, prices and cost
603 trends, with particular attention to factors that contribute to cost growth within the
604 commonwealth's health care system.

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

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

607 (d) The commission shall identify as witnesses for the public hearing a representative sample of
608 providers, provider organizations, payers and others, including: (i) at least 3 academic medical

609 centers, including the 2 acute hospitals with the highest level of net patient service revenue; (ii)
610 at least 3 disproportionate share hospitals, including the 2 hospitals whose largest per cent of
611 gross patient service revenue is attributable to Title XVIII and XIX of the federal Social Security
612 Act or other governmental payers; (iii) community hospitals from at least 3 separate regions of
613 the commonwealth; (iv) freestanding ambulatory surgical centers from at least 3 separate regions
614 of the commonwealth; (v) community health centers from at least 3 separate regions of the
615 commonwealth; (vi) the 5 private health care payers with the highest enrollments in the
616 commonwealth; (vii) any managed care organization that provides health benefits under Title
617 XIX or under the commonwealth care health insurance program; (viii) the group insurance
618 commission; (ix) at least 3 municipalities that have adopted chapter 32B; (x) at least 4 provider
619 organizations, at least 2 of which shall be certified as accountable care organizations, 1 of which
620 has been certified as a model ACO, which shall be from diverse geographic regions of the
621 commonwealth; and (xi) any witness identified by the attorney general or the center.

622 (e) Witnesses shall provide testimony under oath and subject to examination and cross
623 examination by the commission, the executive director of the center and the attorney general at
624 the public hearing in a manner and form to be determined by the commission, including, but not
625 limited to: (i) in the case of providers and provider organizations, testimony concerning payment
626 systems, care delivery models, payer mix, cost structures, administrative and labor costs, capital
627 and technology cost, adequacy of public payer reimbursement levels, reserve levels, utilization
628 trends, relative price, quality improvement and care-coordination strategies, investments in
629 health information technology, the relation of private payer reimbursement levels to public payer
630 reimbursements for similar services, efforts to improve the efficiency of the delivery system,
631 efforts to reduce the inappropriate or duplicative use of technology and the impact of price

632 transparency on prices; and (ii) in the case of private and public payers, testimony concerning
633 factors underlying premium cost and rate increases, the relation of reserves to premium costs,
634 efforts by the payer to reduce the use of fee-for-service payment mechanisms, the payer's efforts
635 to develop benefit design, network design and payment policies that enhance product
636 affordability and encourage efficient use of health resources and technology including utilization
637 of alternative payment methodologies, efforts by the payer to increase consumer access to health
638 care information, efforts by the payer to promote the standardization of administrative practices,
639 the impact of price transparency on prices and any other matters as determined by the
640 commission. The commission shall solicit testimony from any payer which has been identified
641 by the center's annual report under subsection (a) of section 16 of chapter 12C as (1) paying
642 providers more than 10 per cent above or more than 10 per cent below the average relative price
643 or (2) entering into alternative payment contracts that vary by more than 10 per cent. Any payer
644 identified by the center's report shall explain the extent of price variation between the payer's
645 participating providers and describe any efforts to reduce such price variation.

646 (f) In the event that the center's annual report under subsection (a) of section 16 of
647 chapter 12C finds that the percentage change in total health care expenditures exceeded the
648 health care cost benchmark in the previous calendar year, the commission may identify
649 additional witnesses for the public hearing. Witnesses shall provide testimony subject to
650 examination and cross examination by the commission, the executive director of the center and
651 attorney general at the public hearing in a manner and form to be determined by the commission,
652 including, but not limited to: (i) testimony concerning unanticipated events that may have
653 impacted the total health care cost expenditures, including, but not limited to, a public health
654 crisis such as an outbreak of a disease, a public safety event or a natural disaster; (ii) testimony

655 concerning trends in patient acuity, complexity or utilization of services; (iii) testimony
656 concerning trends in input cost structures, including, but not limited to, the introduction of new
657 pharmaceuticals, medical devices and other health technologies; (iv) testimony concerning the
658 cost of providing certain specialty services, including, but not limited to, the provision of health
659 care to children, cancer-related health care and medical education; (v) testimony related to
660 unanticipated administrative costs for carriers, including, but not limited to, costs related to
661 information technology, administrative simplification efforts, labor costs and transparency
662 efforts; (vi) testimony related to costs due the implementation of state or federal legislation or
663 government regulation; and (vii) any other factors that may have led to excessive health care cost
664 growth.

665 (g) The commission shall compile an annual report concerning spending trends and
666 underlying factors, along with any recommendations for strategies to increase the efficiency of
667 the health care system. The report shall be based on the commission's analysis of information
668 provided at the hearings by providers, provider organizations and insurers, registration data
669 collected under section 11, data collected by the center for health information and analysis under
670 sections 8, 9 and 10 of chapter 12C and any other information the commission considers
671 necessary to fulfill its duties under this section, as further defined in regulations promulgated by
672 the commission. The report shall be submitted to the chairs of the house and senate committees
673 on ways and means and the chairs of the joint committee on health care financing and shall be
674 published and available to the public not later than December 31 of each year. The report shall
675 include any legislative language necessary to implement the recommendations.

676 Section 9. (a) Not later than April 15 of every year, the board shall establish a health care
677 cost growth benchmark for the average growth in total health care expenditures in the

678 commonwealth for the next calendar year. The commission shall establish procedures to
679 prominently publish the annual health care cost growth benchmark on the commission's website.

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

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

686 (2) For calendar years 2018 through 2022, the health care cost growth benchmark
687 shall be equal to the growth rate of potential gross state product established under said section
688 7H½ of said chapter 29, minus 0.5 per cent.

689 (3) For calendar years 2023 and beyond, the health care cost growth benchmark
690 shall be equal to the growth rate of potential gross state product established under said section
691 7H½ of said chapter 29.

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

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

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

722 (f) Prior to making any recommended modification to the health care cost growth
723 benchmark under subsections (c), (d) and (e), the board shall hold a public hearing on any such
724 recommended modification. The public hearing shall be based on the report submitted by the
725 center under section 16 of chapter 12C comparing the growth in total health care expenditures to
726 the health care cost growth benchmark for the previous calendar year, any other data provided by
727 the center and such other pertinent information or data as may be available to the board. The
728 hearings shall examine health care provider, provider organization and private and public health
729 care payer costs, prices and cost trends, with particular attention to factors that contribute to cost
730 growth within the commonwealth's health care system, and whether, based on the testimony,
731 information and data, a modification in the health care cost growth benchmark is appropriate.
732 The commission shall provide public notice of such hearing at least 45 days prior to the date of
733 the hearing, including notice to the joint committee on health care financing. The joint committee
734 on health care financing may participate in the hearing. The commission shall identify as
735 witnesses for the public hearing a representative sample of providers, provider organizations,
736 payers and such other interested parties as the commission may determine. Any other interested
737 parties may testify at the hearing.

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

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

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

750 (c) For calendar year 2015, if the commission finds, based on the center's annual report,
751 the commission's annual cost trend hearings or any other pertinent information, that the average
752 percentage change in cumulative total health care expenditures from 2013 to 2014 exceeded the
753 average health care cost growth benchmark from 2013 to 2014, and in order to support the state's
754 efforts to meet future health care cost growth benchmarks, as established in section 9, the
755 commission shall establish procedures to assist health care entities to improve efficiency and
756 reduce cost growth by requiring certain health care entities to file and implement a performance
757 improvement plan.

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

765 (d) In addition to the notice provided under subsection (b), the commission may require
766 any health care entity that is identified by the center under section 16 of chapter 12C as

767 exceeding the health care cost growth benchmark established under section 9 to file a
768 performance improvement plan with the commission. The commission shall provide written
769 notice to such health care entity that they are required to file a performance improvement plan.
770 Within 45 days of receipt of such written notice, the health care entity shall either:

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

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

774 (e) The health care entity may file any documentation or supporting evidence with the
775 commission to support the health care entity's application to waive or extend the requirement to
776 file a performance improvement plan. The commission shall require the health care entity to
777 submit any other relevant information it deems necessary in considering the waiver or extension
778 application; provided, however, that such information shall be made public at the discretion of
779 the commission.

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

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

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

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

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

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

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

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

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

809 expected outcomes and a timetable for implementation. The timetable for a performance
810 improvement plan shall not exceed 18 months.

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

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

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

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

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

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

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

846 (q) If the commission determines that a health care entity has: (i) willfully neglected to
847 file a performance improvement plan with the commission within 45 days as required under
848 subsection (d); (ii) failed to file an acceptable performance improvement plan in good faith with
849 the commission; (iii) failed to implement the performance improvement plan in good faith; or
850 (iv) knowingly failed to provide information required by this section to the commission or that
851 knowingly falsifies the same, the commission may assess a civil penalty to the health care entity

852 of not more than \$500,000. The commission shall seek to promote compliance with this section
853 and shall only impose a civil penalty as a last resort.

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

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

859 Section 11. (a) The commission shall develop and administer a registration program for
860 provider organizations. A provider organization shall be registered for a term of 2 years and
861 renewable under like terms. The commission shall coordinate with state agencies including, but
862 not limited to, the center, the division of insurance, the executive office of health and human
863 services, the office of Medicaid and the department of public health to minimize duplicative
864 reporting requirements. The commission may enter interagency service agreements to perform
865 these functions including but not limited to the sharing of data collected. The commission, in
866 consultation with the center, shall promulgate such regulations as may be necessary to ensure the
867 uniform reporting of data collected under this section.

868 (b) The commission shall require that all provider organizations report the following
869 information for registration and renewal: (i) organizational charts showing the ownership,
870 governance and operational structure of the provider organization, including any clinical
871 affiliations, parent entities, corporate affiliates, and community advisory boards; (ii) the number
872 of affiliated health care professional full-time equivalents and the number of professionals

873 affiliated with or employed by the organization; (iii) the name and address of licensed facilities;
874 and (iv) such other information as the commission considers appropriate.

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

883 (d) The commission shall support the division of insurance in its review of risk-bearing
884 provider organizations under chapter 176U and the center in its efforts to collect and analyze
885 data. The commission shall promulgate regulations setting forth a process for provider
886 organizations to submit proposed changes to its structure.

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

890 Section 12. (a) No provider or provider organization may negotiate network contracts
891 with any carrier or third-party administrator except for a provider or provider organizations
892 which are registered under this chapter and regulations promulgated under this chapter; provided,
893 however, that nothing in this chapter shall require a provider or provider organization with a
894 patient panel of 15,000 or fewer or which represents providers who collectively receive, less than

895 \$25,000,000 in annual net patient service revenue from carriers or third-party administrators to
896 be registered if such provider or provider is not a risk-bearing provider organization.

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

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

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

915 (b) In addition to the grounds for a cost and market impact review set forth in subsection
916 (a), if the commission finds, based on the center's annual report, that the percentage change in

917 total health care expenditures exceeded the health care cost growth benchmark in the previous
918 calendar year, the commission may conduct a cost and market impact review of any provider
919 organization identified by the center under section 16 of chapter 12C.

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

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

929 (i) the provider or provider organization's size and market share within its
930 primary service areas by major service category, and within its dispersed service areas; (ii) the
931 provider or provider organization's prices for services, including its relative price compared to
932 other providers for the same services in the same market; (iii) the provider or provider
933 organization's health status adjusted total medical expense, including its health status adjusted
934 total medical expense compared to similar providers; (iv) the quality of the services it provides,
935 including patient experience; (v) provider cost and cost trends in comparison to total health care
936 expenditures statewide; (vi) the availability and accessibility of services similar to those
937 provided, or proposed to be provided, through the provider or provider organization within its
938 primary service areas and dispersed service areas; (vii) the provider or provider organization's

939 impact on competing options for the delivery of health care services within its primary service
940 areas and dispersed service areas including, if applicable, the impact on existing service
941 providers of a provider or provider organization's expansion, affiliation, merger or acquisition, to
942 enter a primary or dispersed service area in which it did not previously operate; (viii) the
943 methods used by the provider or provider organization to attract patient volume and to recruit or
944 acquire health care professionals or facilities; (ix) the role of the provider or provider
945 organization in serving at-risk, underserved and government payer patient populations, including
946 those with behavioral, substance use disorder and mental health conditions, within its primary
947 service areas and dispersed service areas; (x) the role of the provider or provider organization in
948 providing low margin or negative margin services within its primary service areas and dispersed
949 service areas; (xi) consumer concerns, including but not limited to, complaints or other
950 allegations that the provider or provider organization has engaged in any unfair method of
951 competition or any unfair or deceptive act or practice; and (xii) any other factors that the
952 commission determines to be in the public interest.

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

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

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

969 (h) When the commission, under subsection (f), refers a report on a provider or provider
970 organization to the attorney general, the attorney general may: (i) conduct an investigation to
971 determine whether the provider or provider organization engaged in unfair methods of
972 competition or anti-competitive behavior in violation of chapter 93A or any other law; (ii) report
973 to the commission in writing the findings of the investigation and a conclusion as to whether the
974 provider or provider organization engaged in unfair methods of competition or anti-competitive
975 behavior in violation of chapter 93A or any other law; and (iii) if appropriate, take action under
976 chapter 93A or any other law to protect consumers in the health care market. The commission's
977 final report may be evidence in any such action.

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

980 (j) The commission shall adopt regulations for conducting cost and market impact
981 reviews and for administering this section. These regulations shall include definitions of
982 material change and non-material change, primary service areas, dispersed service areas,
983 dominant market share, materially higher prices and materially higher health status adjusted total

984 medical expenses, and any other terms as necessary. All regulations promulgated by the
985 commission shall comply with chapter 30A.

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

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

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

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

1001 (3) encouraging shared decision-making for preference-sensitive conditions such as
1002 chronic back pain, early stage of breast and prostate cancers, hip osteoarthritis, and cataracts;
1003 provided that shared decision-making shall be conducted on, but not be limited to, long-term care
1004 and supports and palliative care; and

1005 (4) ensuring that patient-centered medical homes develop and maintain appropriate
1006 comprehensive care plans for their patients with complex or chronic conditions, including an
1007 assessment of health risks and chronic conditions.

1008 (5) such other criteria as the commission deems appropriate.

1009 In developing these standards, the commission shall consult with national and local
1010 organizations working on medical home models, relevant state agencies, health plans,
1011 physicians, nurse practitioners, behavioral health providers, hospitals, social workers, other
1012 health care providers and consumers. Furthermore, the commission shall consult with the
1013 department of public health to maximize opportunities for administrative simplification and
1014 regulatory consistency.

1015 (b) Nothing in this section shall be construed as prohibiting a primary care provider,
1016 behavioral health provider or specialty care provider from being certified as a patient-centered
1017 medical home; provided, that such providers meet the standards set by the commission in
1018 accordance with this section or are recognized by the National Committee for Quality Assurance
1019 as a patient-centered medical home.

1020 (c) Certification as a patient-centered medical home is voluntary. Primary care providers,
1021 behavioral health providers and specialty care providers certified by the commission as a patient-
1022 centered medical home shall renew their certification every 2 years under like terms.

1023 (d) A primary care provider or specialty care provider certified as a patient-centered
1024 medical home shall have the ability to assess and provide or arrange for, and coordinate care
1025 with, mental health and substance abuse services, to the extent determined by the commission. A
1026 behavioral health provider or specialty care provider certified as a patient-centered medical home

1027 shall have the ability to assess and provide or arrange for, and coordinate care with, primary care
1028 services, to the extent determined by the commission.

1029 (e) By July 1, 2014, the commission, in consultation with the office of Medicaid, shall
1030 establish a patient-centered medical home training for patient-centered medical homes to learn
1031 the core competencies of the patient-centered medical home model. The commission may require
1032 participation in such training as a condition of certification.

1033 (f) For continued certification by the commission under this section, the commission may
1034 establish and monitor specific quality standards. Such quality standards shall be developed with
1035 reference to the standard quality measure set established by section 14 of chapter 12C.

1036 (g) In providing after-hours care, a patient-centered medical home may enter into a
1037 cooperative agreement with another patient-centered medical home, primary care practice,
1038 limited service clinic, as defined by the department of public health, Medicare-certified home
1039 health agency for those patients that receive home-health services, or urgent care center to
1040 provide after-hours care for their patients.

1041 (h) The commission shall develop a model payment system for patient-centered medical
1042 homes certified under this section or recognized by the National Committee for Quality
1043 Assurance as a patient-centered medical home. In developing the model payment system, the
1044 commission shall consider, but not be limited to, per-patient payments, payment levels based on
1045 care-complexity, and payments for care coordination, clinical management, quality performance
1046 and shared savings. Development of the model patient-centered medical home payment system
1047 shall be completed by January 1, 2014.

1048 (i) Payers may make patient-centered medical home payments to network providers
1049 certified as a patient-centered medical home under this section or recognized by the National
1050 Committee for Quality Assurance as a patient-centered medical home, or equivalent. Payers may
1051 use the model payment system developed by the commission or any other medical home
1052 payment system the carrier deems appropriate.

1053 (j) The commission shall develop and distribute a directory of key existing referral
1054 systems and resources that can assist patients in obtaining housing, food, transportation, child
1055 care, elder services, long-term care services, peer services and other community-based services.
1056 This directory shall be made available to patient-centered medical homes in order to connect
1057 patients to services in their community.

1058 (k) Nothing in this section shall preclude the continuation of existing patient-centered
1059 medical homes or medical home programs currently operating or under development.

1060 Section 15. (a) The commission shall establish a process for certain registered provider
1061 organizations to be certified as accountable care organizations, herein referred to as ACOs;
1062 provided that no provider organization is required to become an ACO. The ACO shall be
1063 certified for a term of 2 years and renewable under like terms. The purpose of the ACO
1064 certification process shall be to encourage the adoption of integrated delivery care systems in the
1065 commonwealth for the purpose of cost containment, quality improvement and patient protection.
1066 The commission shall create a common application form for provider organizations that wish to
1067 apply to the commission. Within 30 days of an application submission, the commission may
1068 require the applicant to provide additional information.

1069 (b) The commission shall establish minimum standards for certified ACOs. A certified
1070 ACO shall: (i) be organized or registered as a separate legal entity from its ACO participants;
1071 (ii) have a governance structure that includes an administrative officer, a medical officer, and
1072 patient or consumer representation; (iii) receive reimbursements or compensation from
1073 alternative payment methodologies; (iv) have functional capabilities to coordinate financial
1074 payments amongst its providers; (v) have significant implementation of interoperable health
1075 information technology, as determined by the commission, for the purposes of care delivery
1076 coordination and population management; (vi) develop and file an internal appeals plan as
1077 required for risk-bearing provider organizations under section 24 of chapter 176O; provided, that
1078 said plan shall be approved by the office of patient protection; provided further, that the plan
1079 shall be a part of a membership packet for newly enrolled individuals; (vii) provide medically
1080 necessary services across the care continuum including behavioral and physical health services,
1081 as determined by the commission through regulations, internally or through contractual
1082 agreements; provided, that any medically necessary service that is not internally available shall
1083 be provided to a patient through services outside the ACO; (viii) implement systems that allow
1084 ACO participants to report the pricing of services, as defined by the commission through
1085 regulations; further provided that ACO participants shall have the ability to provide patients with
1086 relevant price information when contemplating their care and potential referrals; (ix) obtain a
1087 risk certificate from the division of insurance under chapter 176U; and (x) shall engage patients
1088 in shared decision-making, including, but not limited to, shared-decision making on palliative
1089 care and long-term care services and supports.

1090 (c) The commission may establish additional standards for an ACO. In developing
1091 additional standards for ACO certification, the commission shall consider the following goals for
1092 ACOs:

1093 (1) to reduce the growth of health status adjusted total medical expenses over time,
1094 consistent with the state's efforts to meet the health care cost growth benchmark established
1095 under section 9;

1096 (2) to improve the quality of health services provided, as measured by the statewide
1097 quality measure set and other appropriate measures, as established by the commission;

1098 (3) to ensure patient access to health care services across the care continuum, including,
1099 but not limited to, access to: preventive and primary care services; emergency services;
1100 hospitalization services; ambulatory patient services; mental health, substance use disorder and
1101 behavioral health services; access to specialty care units, including, but are not limited to, burn,
1102 coronary care, cancer care, including the services of a comprehensive cancer center, neonatal
1103 care, post-obstetric and post operative recovery care, pulmonary care, renal dialysis and surgical,
1104 including trauma and intensive care units; pediatric services; obstetrics and gynecology services;
1105 diagnostic imaging and screening services; clinical laboratory and pathology services; maternity
1106 and newborn care services and related mental health outcomes; radiation therapy and treatment
1107 services; skilled nursing facilities; family planning services; home health services; treatment and
1108 prevention services for alcohol and other drug abuse; breakthrough technologies and treatments;
1109 allied health services including, but not limited to, advance practice nurses, optometric care,
1110 direct access to chiropractic services and physical therapy, occupational therapists, dental care,
1111 midwifery services, and end-of-life care services, including hospice and palliative care; and

1112 establishing mechanisms to protect patient provider choice, including parameters for out-of-ACO
1113 arrangements;

1114 (4) to promote alternative payment methodologies consistent with the standards
1115 developed by the commission and the adoption of payment incentives that improve quality and
1116 care coordination, including, but not limited to, incentives to reduce avoidable hospitalizations,
1117 avoidable readmissions, adverse events and unnecessary emergency room visits; incentives to
1118 reduce racial, ethnic and linguistic health disparities in the patient population; and in all cases
1119 ensuring that alternative payment methodologies do not create any incentive to deny or limit
1120 medically necessary care, especially for patients with high risk factors or multiple health
1121 conditions;

1122 (5) to improve access to certain primary care services, including, but not limited to, by
1123 having a demonstrated primary care and care coordination capacity and a minimum number of
1124 practices engaged in becoming patient centered medical homes including certified patient
1125 centered medical homes;

1126 (6) to improve access to health care services and quality of care for vulnerable
1127 populations including, but not limited to, children, the elderly, low-income individuals,
1128 individuals with disabilities, individuals with chronic illnesses and racial and ethnic minorities,
1129 including demonstrating an ability to provide culturally and linguistically appropriate care,
1130 patient education and outreach provided by community health workers.

1131 (7) to promote the integration of mental health, substance use disorder and behavioral
1132 health services with primary care services including, but not limited to, the establishment of

1133 behavioral health medical homes, recovery coaching and peer support and services provided by
1134 peer support workers, certified peer specialists and licensed alcohol and drug counselors;

1135 (8) to promote patient-centeredness by, including, but not limited to, establishing
1136 mechanisms to conduct patient outreach and education on the necessity and benefits of care
1137 coordination, including group visits and chronic disease self-management programs;
1138 demonstrating an ability to effectively involve patients in care transitions to improve the
1139 continuity and quality of care across settings, with case manager follow up; demonstrating an
1140 ability to engage and activate patients at home, through methods such as home visits or
1141 telemedicine, to improve self-management; establishing mechanisms to evaluate patient
1142 satisfaction with the access and quality of their care; establishing mechanisms between payers
1143 and the provider organization such that any shared savings between the provider and the payer
1144 shall contain a mechanism to return a percentage of the savings to the ACO patients; and
1145 establishing mechanisms to protect patient provider choice, including parameters for accessing
1146 care outside of the ACO;

1147 (9) to adopt certain health information technology, data analysis functions and
1148 performance management programs, including, but not limited to, the ability to aggregate and
1149 analyze clinical data; the ability to electronically exchange patient summary records across
1150 providers who are ACO participants and other providers in the community to ensure continuity
1151 of care; the ability to provide access to multi-payer claims data and performance reports and the
1152 ability to share performance feedback on a timely basis with participating providers; the ability
1153 to enable the beneficiary access to electronic health information, provided that the patient has
1154 provided consent; and the utilization of a proven performance management program, including,
1155 but not limited to, participation in the 2011 and 2012 Health Care Criteria for Performance

1156 Excellence as developed in conjunction with the Baldrige Criteria for Performance Excellence
1157 administered by the National Institutes of Standards and Technology of the United States
1158 Department of Commerce;

1159 (10) to demonstrate excellence in the area of managing chronic disease and care
1160 coordination, as managed by a physician, nurse practitioner, registered nurse, physician assistant
1161 or social worker, and as evidenced by the success of previous or existing care coordination, pay
1162 for performance, patient centered medical home, quality improvement or health outcomes
1163 improvement initiatives, including, but not limited to, a demonstrated commitment to reducing
1164 avoidable hospitalizations, adverse events and unnecessary emergency room visits;

1165 (11) to promote protocols for provider integration, both with providers within and outside
1166 of the provider organization, including, but not limited to, clinical integration of the medical
1167 director of the laboratory, accredited or certified under the federal Clinical Laboratory
1168 Improvements Act of 1988, providing these services to the organization;

1169 (12) to promote community-based wellness programs and community health workers,
1170 consistent with efforts funded by the department of public health through the Prevention and
1171 Wellness Trust Fund established in section 2G of chapter 111 and to promote other activities that
1172 integrate community public health interventions with an emphasis on the social determinants of
1173 health and which have been proven to improve health;

1174 (13) to promote the health and well being of children, including, but not limited to,
1175 improving access to pediatric care, providing access to mental and behavioral health services for
1176 children, developing and improving pediatric quality measures, developing and improving on
1177 pediatric risk adjustments.

1178 (14) to promote worker training programs and skills training opportunities for employees
1179 of the provider organization, consistent with efforts funded by the secretary of labor and
1180 workforce development through the Health Care Workforce Transformation Trust Fund;

1181 (15) to adopt certain governance structure standards, including standards related to
1182 financial conflicts of interest and transparency; and

1183 (16) any other requirements the commission considers necessary.

1184 (d) The commission shall update the standards for certification as an ACO at least every
1185 2 years, or at such other times as the commission determines necessary. The commission shall
1186 not deny an ACO certification based solely on the geographic location or size of the provider
1187 organization.

1188 (e) The commission shall create a designation process for Model ACOs only to be
1189 conferred on ACOs that have demonstrated excellence in adopting the best practices for quality
1190 improvement, cost containment and patient protections, as determined by the commission. In
1191 developing this standard of excellence, the commission shall review the standards set forth in
1192 subsection (c).

1193 (f) All ACOs shall publish the standards used by the ACO to determine which providers
1194 of free-standing ancillary services shall be approved to provide services to ACO patients. Free-
1195 standing ancillary services shall include, but shall not be limited to, durable medical equipment
1196 services, laboratory services, imaging services, dialysis centers, and services provided by free-
1197 standing diagnostic, non-hospital surgery centers. A provider of these services shall be informed
1198 in writing by the ACO of the standards by which they were accepted or rejected as an approved
1199 provider of these free-standing ancillary services for ACO patients.

1200 The commission shall create a review process for aggrieved providers under this
1201 subsection that are denied approval by an ACO as a provider of free-standing ancillary services
1202 for ACO patients. For such process, the commission may review the following: (1) a comparison
1203 of the costs of services between an aggrieved provider and the costs of services provided within
1204 the ACO; (2) a comparison of the quality of services between an aggrieved provider and the
1205 quality of services provided within the ACO; (3) a comparison of the efficiency of services
1206 between an aggrieved provider and efficiency of services provided within the ACO; and (4) the
1207 extent to which the aggrieved provider meets the published standards used by the ACO to
1208 determine inclusion as an approved provider for ACO patients.

1209 (g) The commission shall promulgate any necessary regulations to administer this
1210 section. In promulgating such regulations, the regulations shall, to the extent applicable and
1211 feasible, be consistent with federal law, regulations, demonstrations and rules governing
1212 accountable care organizations and shared savings programs.

1213 Section 16. (a) There is hereby established within the commission an office of patient
1214 protection. The office shall:- (1) have the authority to administer and enforce the standards and
1215 procedures established by sections 13, 14, 15 and 16 of chapter 176O. The commission shall
1216 promulgate such regulations to enforce this section. Such regulations shall protect the
1217 confidentiality of any information about a carrier or utilization review organization, as defined in
1218 said chapter 176O, which, in the opinion of the office, and in consultation with the division of
1219 insurance, is proprietary in nature and is not in the public interest to disclose. Utilization review
1220 criteria, medical necessity criteria and protocols must be made available to the public at no
1221 charge regardless of proprietary claims. The regulations authorized by this section shall be

1222 consistent with, and not duplicate or overlap with, regulations promulgated by the bureau of
1223 managed care established in the division of insurance pursuant to said chapter 176O;

1224 (2) make managed care information collected by the office readily accessible to
1225 consumers on the commission's website. The information shall, at a minimum, include (i) a
1226 chart, prepared by the office, comparing the information obtained on premium revenue expended
1227 for health care services as provided under paragraph (3) of subsection (b) of section 7 of chapter
1228 176O, for the most recent year for which information is available, and (ii) data collected under
1229 paragraph (c);

1230 (3) assist consumers with questions or concerns relating to managed care, including, but
1231 not limited to, exercising the grievance and appeals rights established by sections 13 and 14 of
1232 said chapter 176O;

1233 (4) monitor quality-related health insurance plan information relating to managed care
1234 practices;

1235 (5) regulate the establishment and functions of review panels established by section 14 of
1236 chapter 176O;

1237 (6) periodically advise the commission, the commissioner of insurance, the managed care
1238 oversight board, established by section 16D of chapter 6A, the joint committee on health care
1239 financing and the joint committee on financial services on actions, including legislation, which
1240 may improve the quality of managed care health insurance plans;

1241 (7) administer and grant enrollment waivers under paragraph (4) of subsection (a) of
1242 section 4 of chapter 176J; provided, however, that the office of patient protection may grant a

1243 waiver to an eligible individual who certifies, under penalty of perjury, that such individual did
1244 not intentionally forego enrollment into coverage for which the individual is eligible and that is
1245 at least actuarially equivalent to minimum creditable coverage; provided further, that the office
1246 shall establish, by regulation, standards and procedures for enrollment waivers; and

1247 (8) establish, by regulation, procedures and rules relating to appeals by consumers
1248 aggrieved by restrictions on patient choice, denials of services or quality of care resulting from
1249 any final action of an ACO, and to conduct hearings and issue rulings on appeals brought by
1250 ACO consumers that are not otherwise properly heard through the consumer's payer or provider.

1251 (b) The commission shall establish an external review system for the review of
1252 grievances submitted by or on behalf of insureds of carriers under section 14 of chapter 176O.
1253 The commission shall establish an external review process for the review of grievances
1254 submitted by or on behalf of ACO patients and shall specify the maximum amount of time for
1255 the completion of a determination and review after a grievance is submitted. The commission
1256 shall establish expedited review procedures applicable to emergency situations, as defined by
1257 regulation promulgated by the division.

1258 (c) Each entity that compiles the health plan employer data and information set, so-called,
1259 for the National Committee on Quality Assurance, or collects other information deemed by the
1260 entity as similar or equivalent thereto, shall, upon submitting said data and information sent to
1261 the commission concurrently submit to the office of patient protection a copy thereof, excluding,
1262 at the entity's option, proprietary financial data.

1263 Section 17. The commission shall keep an accurate account of all its activities and of all
1264 its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal

1265 year to its board, to the governor, to the general court, and to the state auditor, such reports to be
1266 in a form prescribed by the board, with the written approval of the auditor. The auditor may
1267 investigate the affairs of the commission, may severally examine the properties and records of
1268 the commission, and may prescribe methods of accounting and of rendering of periodic reports
1269 in relation to projects undertaken by the commission. The commission shall be subject to
1270 biennial audit by the state auditor.

1271 Section 18. The commission may adopt regulations to implement this chapter.

1272 SECTION 16. The third sentence of subsection (c) of section 4R of chapter 7 of the
1273 General Laws, as inserted by section 15 of chapter 68 of the acts of 2011, is hereby amended by
1274 striking out the words “division of health care finance and policy” and inserting in place thereof
1275 the following words:- center for health information and analysis.

1276 SECTION 17. Section 22N of said chapter 7, as appearing in the 2010 Official Edition, is
1277 hereby amended by striking out, in lines 10 and 37, the word “118G” and inserting in place
1278 thereof, in each instance, the following word:- 118E.

1279 SECTION 18. Chapter 12 of the General Laws is hereby amended by inserting after
1280 section 11M the following section:-

1281 Section 11N. (a) The attorney general shall monitor trends in the health care market
1282 including, but not limited to, trends in provider organization size and composition, consolidation
1283 in the provider market, payer contracting trends and patient access and quality issues in the
1284 health care market. The attorney general may obtain the following information from a private
1285 health care payer, public health care payer, provider or provider organization, as those terms are
1286 defined in section 1 of chapter 6D: (i) any information that is required to be submitted under

1287 sections 8, 9 and 10 of chapter 12C, (ii) filings, applications and supporting documentation
1288 related to any cost and market impact review under section 13 of chapter 6D (iii) filings,
1289 applications and supporting documentation related to a determination of need application filed
1290 under section 25C of chapter 111; and (iv) filings, applications and supporting documentation
1291 submitted to the federal Centers for Medicare and Medicaid Services or the Office of the
1292 Inspector General for any demonstration project. Under section 17 of chapter 12C and section 8
1293 of chapter 6D and subject to the limitations stated in those sections, the attorney general may
1294 require that any provider, provider organization, private health care payer or public health care
1295 payer produce documents, answer interrogatories and provide testimony under oath related to
1296 health care costs and cost trends , the factors that contribute to cost growth within the
1297 commonwealth’s health care system and the relationship between provider costs and payer
1298 premium rates.

1299 (b) The attorney general may investigate any provider organization referred to the
1300 attorney general by the health policy commission under section 13 of chapter 6D to determine
1301 whether the provider organization engaged in unfair methods of competition or anti-competitive
1302 behavior in violation of chapter 93A or any other law, and, if appropriate, take action under
1303 chapter 93A or any other law to protect consumers in the health care market.

1304 (c) The attorney general may intervene or otherwise participate in efforts by the
1305 commonwealth to obtain exemptions or waivers from certain federal laws regarding provider
1306 market conduct, including, from the federal Office of the Inspector General, a waiver of, or
1307 expansion of, the “safe harbors” provided for under 42 U.S.C. section 1320a-7b and obtaining
1308 from the federal Office of the Inspector General a waiver of, or exemption from, 42 U.S.C.
1309 section 1395nn subsections (a) to (e).

1310 (d) Nothing in this section shall limit the authority of the attorney general to protect
1311 consumers in the health care market under any other law.

1312 SECTION 19. The General Laws are hereby further amended by inserting after chapter
1313 12B the following chapter:-

1314 Chapter 12C

1315 Center for Health Information and Analysis

1316 Section 1. As used in this chapter the following words shall, unless the context clearly
1317 requires otherwise, have the following meanings:-

1318 “Accountable care organization”, or “ACO”, a provider organization certified under
1319 section 15 of chapter 6D.

1320 “Actual costs”, all direct and indirect costs incurred by a hospital or a community health
1321 center in providing medically necessary care and treatment to its patients, determined in
1322 accordance with generally accepted accounting principles.

1323 “Acute hospital”, the teaching hospital of the University of Massachusetts Medical
1324 School and any hospital licensed under section 51 of chapter 111 and which contains a majority
1325 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of
1326 public health.

1327 “Alternative payment contract”, any contract between a provider or provider organization
1328 and a public health care payer or a private health care payer which utilizes alternative payment
1329 methodologies.

1330 “Alternative payment methodologies or methods”, methods of payment that are not solely
1331 based on fee-for-service reimbursements; provided, that “alternative payment methodologies”
1332 may include, but not be limited to, shared savings arrangement, bundled payments, and global
1333 payments; provided further, that “alternative payment methodologies” may include fee-for-
1334 service payments, which are settled or reconciled with a bundled or global payment.

1335 “Ambulatory surgical center”, any distinct entity that operates exclusively to provide
1336 surgical services to patients not requiring hospitalization and meets the requirements of the
1337 federal Health Care Financing Administration for participation in the Medicare program.

1338 “Ambulatory surgical center services”, services described for purposes of the Medicare
1339 program under 42 USC § 1395k(a)(2)(F)(I); provided, that “ambulatory surgical center services”
1340 shall include facility services only and shall not include surgical procedures.

1341 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health
1342 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
1343 176A; a nonprofit medical service corporation organized under chapter 176B; a health
1344 maintenance organization organized under chapter 176G; and an organization entering into a
1345 preferred provider arrangement under chapter 176I, but not including an employer purchasing
1346 coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or
1347 affiliated corporations of the employer; provided that, unless otherwise noted, the term “carrier”
1348 shall not include any entity to the extent it offers a policy, certificate or contract that provides
1349 coverage solely for dental care services or vision care services.

1350 “Case mix”, the description and categorization of a hospital’s patient population
1351 according to criteria approved by the center including, but not limited to, primary and secondary

1352 diagnoses, primary and secondary procedures, illness severity, patient age and source of
1353 payment.

1354 “Center”, the center for health information and analysis.

1355 “Charge”, the uniform price for specific services within a revenue center of a hospital.

1356 “Child”, a person who is under 18 years of age.

1357 “Clinical affiliation”, any relationship between a provider organization and another entity
1358 for the purpose of increasing the level of collaboration in the provision of health care services,
1359 including, but not limited to, sharing of physician resources in hospital or other ambulatory
1360 settings, co-branding, expedited transfers to advanced care settings, provision of inpatient
1361 consultation coverage or call coverage, enhanced electronic access and communication, co-
1362 located services, provision of capital for service site development, joint training programs, video
1363 technology to increase access to expert resources and sharing of hospitalists or intensivists.

1364 “Commission”, the health policy commission established in chapter 6D.

1365 “Community health centers”, health centers operating in conformance with Section 330
1366 of United States Public Law 95-626 and shall include all community health centers which file
1367 cost reports as requested by the center.

1368 “Dependent”, the spouse and children of any employee if such persons would qualify for
1369 dependent status under the Internal Revenue Code or for whom a support order could be granted
1370 under chapters 208, 209 or 209C.

1371 “Dispersed service area,” a geographic area of the commonwealth in which a provider
1372 organization delivers health care services; provided, however, that the center may by regulation

1373 establish standards to determine dispersed service areas based on the number of zip codes, towns,
1374 counties or primary service areas, which standards may vary based upon the population density
1375 of various regions of the commonwealth.

1376 “Eligible person”, a person who qualifies for financial assistance from a governmental
1377 unit in meeting all or part of the cost of general health supplies, care or rehabilitative services
1378 and accommodations.

1379 “Employee”, a person who performs services primarily in the commonwealth for
1380 remuneration for a commonwealth employer; provided, that “employee” shall not include a
1381 person who is self-employed.

1382 “Employer”, an employer as defined in section 1 of chapter 151A.

1383 “Executive director”, the executive director of the center.

1384 “Facility”, a licensed institution providing health care services or a health care setting,
1385 including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical
1386 or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory
1387 and imaging centers, and rehabilitation and other therapeutic health settings.

1388 “Fee-for-service”, a payment mechanism in which all reimbursable health care activity is
1389 described and categorized into discreet and separate units of service and each provider is
1390 separately reimbursed for each discrete service rendered to a patient.

1391 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
1392 ends in the calendar year by which it is identified.

1393 “General health supplies, care or rehabilitative services and accommodations”, all
1394 supplies, care and services of medical, behavioral health, substance use disorder, mental health,
1395 optometric, dental, surgical, chiropractic, podiatric, psychiatric, therapeutic, diagnostic,
1396 rehabilitative, supportive or geriatric nature, including inpatient and outpatient hospital care and
1397 services, and accommodations in hospitals, sanatoria, infirmaries, convalescent and nursing
1398 homes, retirement homes, facilities established, licensed or approved under chapter 111B and
1399 providing services of a medical or health-related nature, and similar institutions including those
1400 providing treatment, training, instruction and care of children and adults; provided, however, that
1401 rehabilitative service shall include only rehabilitative services of a medical or health-related
1402 nature which are eligible for reimbursement under Title XIX of the Social Security Act.

1403 “Governmental unit”, the commonwealth, any department, agency board or commission
1404 of the commonwealth and any political subdivision of the commonwealth.

1405 “Gross patient service revenue”, the total dollar amount of a hospital’s charges for
1406 services rendered in a fiscal year.

1407 “Health care professional”, a physician or other health care practitioner licensed,
1408 accredited, or certified to perform specified health services consistent with law.

1409 “Health care cost growth benchmark”, the projected annual percentage change in total
1410 health care expenditures in the commonwealth, as established in section 9 of chapter 6D.

1411 “Health care services”, supplies, care and services of medical, behavioral health,
1412 substance use disorder, mental health, surgical, optometric, dental, podiatric, chiropractic,
1413 psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature
1414 including, but not limited to, inpatient and outpatient acute hospital care and services; services

1415 provided by a community health center or by a sanatorium, as included in the definition of
1416 “hospital” in Title XVIII of the federal Social Security Act, and treatment and care compatible
1417 with such services or by a health maintenance organization.

1418 “Health insurance company”, a company as defined in section 1 of chapter 175 which
1419 engages in the business of health insurance.

1420 “Health insurance plan”, the medicare program or an individual or group contract or other
1421 plan providing coverage of health care services and which is issued by a health insurance
1422 company, a hospital service corporation, a medical service corporation or a health maintenance
1423 organization.

1424 “Health maintenance organization”, a company which provides or arranges for the
1425 provision of health care services to enrolled members in exchange primarily for a prepaid per
1426 capita or aggregate fixed sum as further defined in section 1 of chapter 176G.

1427 “Health status adjusted total medical expenses”, the total cost of care for the patient
1428 population associated with a provider group based on allowed claims for all categories of
1429 medical expenses and all non-claims related payments to providers, adjusted by health status,
1430 and expressed on a per member per month basis, as calculated under section 9 and the
1431 regulations promulgated by the center.

1432 “Hospital”, any hospital licensed under section 51 of chapter 111, the teaching hospital of
1433 the University of Massachusetts Medical School and any psychiatric facility licensed under
1434 section 19 of chapter 19.

1435 “Hospital service corporation”, a corporation established to operate a nonprofit hospital
1436 service plan as provided in chapter 176A.

1437 “Major service category,” a set of service categories to be established by regulation,
1438 which may include: (i) acute hospital inpatient services, by major diagnostic category; (ii)
1439 outpatient and ambulatory services, by categories as defined by the Centers for Medicare and
1440 Medicaid, or as established by regulation, not to exceed 15, including a residual category for “all
1441 other” outpatient and ambulatory services that do not fall within a defined category; (iii)
1442 behavioral, substance use disorder and mental health services by categories as defined by the
1443 Centers for Medicare and Medicaid, or as established by regulation; (iv) professional services, by
1444 categories as defined by the Centers for Medicare and Medicaid, or as established by regulation;
1445 and (v) sub-acute services, by major service line or clinical offering, as defined by regulation.

1446 “Medicaid program”, the medical assistance program administered by the division of
1447 medical assistance under chapter 118E and in accordance with Title XIX of the Federal Social
1448 Security Act or any successor statute.

1449 “Medical assistance program”, the medicaid program, the Veterans Administration health
1450 and hospital programs and any other medical assistance program operated by a governmental
1451 unit for persons categorically eligible for such program.

1452 “Medical service corporation”, a corporation established to operate a nonprofit medical
1453 service plan as provided in chapter 176B.

1454 “Medicare program”, the medical insurance program established by Title XVIII of the
1455 Social Security Act.

1456 “Net cost of private health insurance”, the difference between health premiums earned
1457 and benefits incurred, which shall consist of: (i) all categories of administrative expenditures, as
1458 included in medical loss ratio regulations promulgated by the division of insurance; (ii) net
1459 additions to reserves; (iii) rate credits and dividends; and (iv) profits or losses, or as otherwise
1460 defined by regulations promulgate by the center.

1461 “Network contract”, a contract entered between a provider or provider organization and a
1462 carrier or third-party administrator concerning payment for the provision of heath care services.

1463 “Non-acute hospital”, any hospital which is not an acute hospital.

1464 “Patient”, any natural person receiving health care services.

1465 “Patient-centered medical home”, a model of health care delivery designed to provide a
1466 patient with a single point of coordination for all their health care, including primary, specialty,
1467 post-acute and chronic care, which is (i) patient-centered; (ii) comprehensive, integrated and
1468 continuous; and (iii) delivered by a team of health care professionals to manage a patient’s care,
1469 reduce fragmentation, and improve patient outcomes.

1470 “Primary service area”, a geographic area of the commonwealth in which consumers are
1471 likely to travel to obtain health services; provided, however, that the center may by regulation
1472 establish standards to determine primary service areas by major service category, which
1473 standards may vary based upon the population density of various regions of the commonwealth.

1474 “Private health care payer”, a carrier authorized to transact accident and health insurance
1475 under chapter 175, a nonprofit hospital service corporation licensed under chapter 176A, a
1476 nonprofit medical service corporation licensed under chapter 176B, a dental service corporation

1477 organized under chapter 176E, an optometric service corporation organized under chapter 176F,
1478 a self-insured plan, to the extent allowable under federal law governing health care provided by
1479 employers to employees, or a health maintenance organization licensed under chapter 176G.

1480 “Provider”, any person, corporation partnership, governmental unit, state institution or
1481 any other entity qualified under the laws of the commonwealth to perform or provide health care
1482 services.

1483 “Provider organization”, any corporation, partnership, business trust, association or
1484 organized group of persons, which is in the business of health care delivery or management,
1485 whether incorporated or not that represents 1 or more health care providers in contracting with
1486 carriers for the payments of health care services, including but not limited to, physician
1487 organizations, physician-hospital organizations, independent practice associations, provider
1488 networks, accountable care organizations and any other organization that contracts with carriers
1489 for payment for health care services.

1490 “Public health care payer”, the Medicaid program established in chapter 118E; any
1491 carrier or other entity that contracts with the office of Medicaid or the commonwealth health
1492 insurance connector to pay for or arrange the purchase of health care services on behalf of
1493 individuals enrolled in health coverage programs under Titles XIX or XXI, or under the
1494 commonwealth care health insurance program, including prepaid health plans subject to the
1495 provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission
1496 established under chapter 32A; and any city or town with a population of more than 60,000 that
1497 has adopted chapter 32B.

1498 “Purchaser”, a natural person responsible for payment for health care services rendered
1499 by a hospital.

1500 “Quality measures”, the standard quality measure set as defined by the center in section
1501 14.

1502 “Registered provider organization,” a provider organization that has been registered in
1503 accordance with section 11 of chapter 6D.

1504 “Relative prices”, the contractually negotiated amounts paid to providers by each private
1505 and public carrier for health care services, including non-claims related payments and expressed
1506 in the aggregate relative to the payer’s network-wide average amount paid to providers, as
1507 calculated under section 9 and regulations promulgated by the center.

1508 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
1509 patient for a charge.

1510 “Resident”, a person living in the commonwealth, as defined by the center by regulation;
1511 provided, however, that such regulation shall not define a resident as a person who moved into
1512 the commonwealth for the sole purpose of securing health insurance under this chapter; and
1513 provided, further that confinement of a person in a nursing home, hospital or other medical
1514 institution shall not, in and of itself, suffice to qualify such person as a resident.

1515 “Secretary”, the secretary of health and human services.

1516 “Self-employed”, a person who, at common law, is not considered to be an employee and
1517 whose primary source of income is derived from the pursuit of a bona fide business.

1518 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
1519 business, which is not a health insurance plan, and in which the business is liable for the actual
1520 costs of the health care services provided by the plan and administrative costs.

1521 “Self-insured group”, a self-insured or self-funded employer group health plan.

1522 “Specialty hospital”, an acute hospital which qualifies for an exemption from the
1523 medicare prospective payment system regulations or any acute hospital which limits its
1524 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to
1525 children or patients under obstetrical care.

1526 “State institution”, any hospital, sanatorium, infirmary, clinic and other such facility
1527 owned, operated or administered by the commonwealth, which furnishes general health supplies,
1528 care or rehabilitative services and accommodations.

1529 “Surcharge payor”, an individual or entity that pays for or arranges for the purchase of
1530 health care services provided by acute hospitals and ambulatory surgical center services provided
1531 by ambulatory surgical centers; provided, however, that the term “surcharge payor” shall include
1532 a managed care organization; and provided further, that “surcharge payor” shall not include Title
1533 XVIII and Title XIX programs and their beneficiaries or recipients, other governmental
1534 programs of public assistance and their beneficiaries or recipients and the workers’ compensation
1535 program established under chapter 152.

1536 “Third party administrator”, an entity that administers payments for health care services
1537 on behalf of a client in exchange for an administrative fee.

1538 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX
1539 programs, other governmental payers, insurance companies, health maintenance organizations
1540 and nonprofit hospital service corporations; provided, that, “third party payer” shall not include a
1541 purchaser responsible for payment for health care services rendered by a hospital, either to the
1542 purchaser or to the hospital.

1543 “Title XIX”, Title XIX of the Social Security Act, 42 USC 1396 et seq., or any successor
1544 statute enacted into federal law for the same purposes as Title XIX.

1545 “Total health care expenditures”, the annual per capita sum of all health care expenditures
1546 in the commonwealth from public and private sources, including: (i) all categories of medical
1547 expenses and all non-claims related payments to providers, as included in the health status
1548 adjusted total medical expenses reported by the center under subsection (d) of section 8; (ii) all
1549 patient cost-sharing amounts, such as deductibles and copayments; and (iii) the net cost of
1550 private health insurance, or as otherwise defined in regulations promulgated by the center.

1551 Section 2. There is hereby established a center for health information and analysis. There
1552 shall be in the center an executive director, who shall be the administrative head of the center and
1553 who shall be appointed by a majority vote of the attorney general, the state auditor and the
1554 governor for a term of 5 years. The person so appointed shall be selected without regard to
1555 political affiliation and solely on the basis of expertise in health care policy, expertise in health
1556 care finance and such other educational requirements and experience that the attorney general,
1557 state auditor and governor determine are necessary.

1558 In the case of a vacancy in the position of executive director, a successor shall be
1559 appointed in the same manner as the original appointment for the unexpired term. No person
1560 shall be appointed for more than 2 consecutive 5-year terms.

1561 The person so appointed may be removed from office, for cause, by a majority vote of the
1562 attorney general, the state auditor and the governor. Such cause may include substantial neglect
1563 of duty, gross misconduct or conviction of a crime. The reasons for removal of the executive
1564 director shall be stated in writing and shall include the basis for such removal. The writing shall
1565 be sent to the clerk of the senate, the clerk of the house of representative and to the governor at
1566 the time of the removal and shall be a public record.

1567 Section 3. The executive director may appoint and remove, subject to appropriation, such
1568 agents and subordinate officers and employees as the executive director may consider necessary
1569 and may establish such subdivisions within the center as the executive director considers
1570 appropriate to fulfill the following duties: (i) to collect, analyze and disseminate health care
1571 information to assist in the formulation of health care policy and in the provision and purchase of
1572 health care services including, but not limited to, collecting, storing and maintaining data in a
1573 payer and provider claims database; (ii) to provide an analysis of health care spending trends as
1574 compared to the health care cost growth benchmark established by the health policy commission
1575 under section 9 of chapter 6D; (iii) to collect, analyze and disseminate information regarding
1576 providers, provider organizations and payers to increase the transparency and improve the
1577 functioning of the health care system; (iv) to provide information to, and work with, the general
1578 court and other state agencies including, but not limited to, the executive office of health and
1579 human services, the department of public health, the department of mental health, the health care
1580 policy commission, the office of Medicaid and the division of insurance to collect and

1581 disseminate data concerning the cost, price and functioning of the health care system in the
1582 commonwealth and the health status of individuals; (v) to participate in and provide data and
1583 data analysis for annual hearings conducted by the health policy commission concerning health
1584 care provider and payer costs, prices and cost trends; and (vi) report to consumers comparative
1585 health care cost and quality information through the consumer health information website
1586 established under section 20. The center shall make available actual costs and prices of health
1587 care services, as supplied by each provider, to the general public in a conspicuous manner on the
1588 consumer health information website.

1589 Section 4. The position of executive director shall be classified under section 45 of
1590 chapter 30 and the salary shall be determined under section 46C of said chapter 30.

1591 The total amount of all appointee salaries shall not exceed the sum appropriated therefor
1592 by the general court. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E
1593 shall not apply to the executive director of the center. Sections 45, 46 and 46C of chapter 30
1594 shall not apply to any employee of the center.

1595 The executive director may establish personnel regulations for the officers and employees
1596 of the center. The executive director shall file an annual personnel report not later than the first
1597 Wednesday in February with the senate and house committees on ways and means containing the
1598 job classifications, duties and salary of each officer and employee within the center together with
1599 personnel regulations applicable to said officers and employees. The executive director shall file
1600 amendments to such report with the senate and house committees on ways and means whenever
1601 any changes become effective.

1602 Section 5. The center shall adopt and amend rules and regulations, in accordance with
1603 chapter 30A, for the administration of its duties and powers and necessary to effectuate this
1604 chapter; provided, however, that the rules or regulations shall not be construed to impair or in
1605 any way modify the authority of the executive office of health and human services to act,
1606 pursuant to section 16 of chapter 6A of the General Laws, as the single state agency authorized
1607 to supervise and administer the state programs under titles XIX and XXI of the Social Security
1608 Act. The regulations shall be adopted, after notice and hearing, only upon consultation with
1609 representatives of providers, provider organizations, private health care payers and public health
1610 care payers.

1611 The center shall, before adopting regulations under this chapter, consult with other
1612 agencies of the commonwealth and the federal government, affected providers, and affected
1613 payers, as applicable, to ensure that the reporting requirements imposed under the regulations are
1614 not duplicative or excessive. If reporting requirements imposed by the center result in additional
1615 costs for the reporting providers, these costs may be included in any rates promulgated by the
1616 executive office of health and human services or a governmental unit designated by the executive
1617 office for these providers. The center may specify categories of information which may be
1618 furnished under an assurance of confidentiality to the provider; provided, however, that such
1619 assurance shall only be furnished if the information is not to be used for setting rates.

1620 Section 6. In addition to the powers conferred on state agencies, the center shall have the
1621 following powers:

1622 (1) to make, amend and repeal rules and regulations for the management of its affairs;

1623 (2) to make contracts and execute all instruments necessary or convenient for the carrying
1624 on of its business;

1625 (3) to acquire, own, hold, dispose of and encumber personal property and to lease real
1626 property in the exercise of its powers and the performance of its duties; and

1627 (4) to enter into agreements or transactions with any federal, state or municipal agency or
1628 other public institution or with any private individual, partnership, firm, corporation, association
1629 or other entity.

1630 Section 7. Each acute hospital, ambulatory surgical center and surcharge payor shall pay
1631 to the commonwealth an amount for the estimated expenses of the center.

1632 The assessed amount for hospitals and ambulatory surgical centers shall be not less than
1633 33 per cent of the amount appropriated by the general court for the expenses of the center minus
1634 amounts collected from (1) filing fees; (2) fees and charges generated by the center's publication
1635 or dissemination of reports and information; and (3) federal matching revenues received for these
1636 expenses or received retroactively for expenses of predecessor agencies. Each acute hospital and
1637 ambulatory surgical center shall pay the assessed amount multiplied by the ratio of the hospital's
1638 or ambulatory surgical center's gross patient service revenues to the total of all such hospital's
1639 and ambulatory surgical center's gross patient services revenues. Each acute hospital and
1640 ambulatory surgical center shall make a preliminary payment to the center on October 1 of each
1641 year in an amount equal to $\frac{1}{2}$ of the previous year's total assessment. Thereafter, each hospital
1642 and ambulatory surgical center shall pay, within 30 days notice from the center, the balance of
1643 the total assessment for the current year based upon its most current projected gross patient
1644 service revenue. The center shall subsequently adjust the assessment for any variation in actual

1645 and estimated expenses of the center and for changes in hospital or ambulatory surgical center
1646 gross patient service revenue. The estimated and actual expenses shall include an amount equal
1647 to the cost of fringe benefits and indirect expenses, as established by the comptroller under
1648 section 5D of chapter 29. In the event of late payment by any such hospital or ambulatory
1649 surgical center, the treasurer shall advance the amount of due and unpaid funds to the center
1650 before the receipt of the monies in anticipation of the revenues up to the amount authorized in
1651 the then current budget attributable to the assessments and the center shall reimburse the
1652 treasurer for the advances upon receipt of the revenues. This section shall not apply to any state
1653 institution or to any acute hospital which is operated by a city or town.

1654 The assessed amount for surcharge payors shall be not less than 33 per cent of the amount
1655 appropriated by the general court for the expenses of the center minus amounts collected from
1656 (1) filing fees; (2) fees and charges generated by the center's publication or dissemination of
1657 reports and information; and (3) federal matching revenues received for these expenses or
1658 received retroactively for expenses of predecessor agencies. The assessment on surcharge
1659 payors shall be calculated and collected in the same manner as the assessment authorized under
1660 section 68 of chapter 118E.

1661 Section 8. (a) The center shall promulgate such regulations as necessary to ensure the
1662 uniform reporting of revenues, charges, costs, prices, and utilization of health care services and
1663 other such data as the center may require of institutional providers and their parent organizations
1664 and any other affiliated entities, non-institutional providers and provider organizations; provided,
1665 however, that the center may establish reporting thresholds through regulation. Such uniform
1666 reporting shall enable the center to identify, on a patient-centered and provider-specific basis,
1667 statewide and regional trends in the cost, price, availability and utilization of medical, surgical,

1668 diagnostic and ancillary services provided by acute hospitals, nursing homes, chronic care and
1669 rehabilitation hospitals, other specialty hospitals, clinics, including mental health clinics and the
1670 ambulatory care providers as the center may specify. The center shall also promulgate
1671 regulations to require providers to report any agreements through which 1 provider agrees to
1672 furnish another provider with a discount, rebate or any other type of refund or remuneration in
1673 exchange for, or in any way related to, the provision of health care services.

1674 (b) With respect to any acute or non-acute hospital, the center shall, by regulation,
1675 designate information necessary to effectuate this chapter including, but not be limited to, the
1676 filing of a charge book, the filing of cost data and audited financial statements and the
1677 submission of merged billing and discharge data. The center shall, by regulation, designate
1678 standard systems for determining, reporting and auditing volume, case-mix, proportion of low-
1679 income patients and any other information necessary to effectuate this chapter and to prepare
1680 reports comparing acute and non-acute care hospitals by cost, utilization and outcome. The
1681 regulations may require the hospitals to file required information and data by electronic means;
1682 provided, however, that the center shall allow reasonable waivers from the requirement. The
1683 center shall, at least annually, publish a report analyzing the comparative information to assist
1684 third-party payers and other purchasers of health services in making informed decisions. The
1685 report shall include comparative price and service information relative to outpatient mental
1686 health services.

1687 (c) The center shall also collect and analyze such data as it considers necessary in order to
1688 better protect the public's interest in monitoring the financial conditions of acute hospitals. The
1689 information shall be analyzed on an industry-wide and hospital-specific basis and shall include,
1690 but not be limited to: (1) gross and net patient service revenues; (2) sources of hospital revenue,

1691 including revenue excluded from consideration in the establishment of hospital rates and charges
1692 under section 13G of chapter 118E; (3) private sector charges; (4) trends in inpatient and
1693 outpatient case mix, payer mix, hospital volume and length of stay; (5) total payroll as a per cent
1694 of operating expenses, as well as the salary and benefits of the top 10 highest compensated
1695 employees, identified by position description and specialty; and (6) other relevant measures of
1696 financial health or distress.

1697 The center shall publish annual reports and establish a continuing program of
1698 investigation and study of financial trends in the acute hospital industry, including an analysis of
1699 systemic instabilities or inefficiencies that contribute to financial distress in the acute hospital
1700 industry. The reports shall include an identification and examination of hospitals that the center
1701 considers to be in financial distress, including any hospitals at risk of closing or discontinuing
1702 essential health services, as defined by the department of public health under section 51G of
1703 chapter 111, as a result of financial distress.

1704 The center may modify uniform reporting requirements established under subsections (a)
1705 and (b) and may require hospitals to report required information quarterly to effectuate this
1706 subsection.

1707 (d) The center shall publicly report and place on its website information on health status
1708 adjusted total medical expenses including a breakdown of the health status adjusted total medical
1709 expenses by major service category and by payment methodology, relative prices and hospital
1710 inpatient and outpatient costs, including direct and indirect costs under this chapter on an annual
1711 basis; provided, however, that at least 10 days before the public posting or reporting of provider
1712 specific information the affected provider shall be provided the information for review. The

1713 center shall request from the federal Centers for Medicare and Medicaid Services the health
1714 status adjusted total medical expenses of provider groups that serve Medicare patients.

1715 (e) When collecting information or compiling reports intended to compare individual
1716 health care providers, the center shall require that:

1717 (1) providers which are representative of the target group for profiling shall be
1718 meaningfully involved in the development of all aspects of the profile methodology, including
1719 collection methods, formatting and methods and means for release and dissemination;

1720 (2) the entire methodology for collecting and analyzing the data shall be disclosed
1721 to all relevant provider organizations and to all providers under review;

1722 (3) data collection and analytical methodologies shall be used that meet accepted
1723 standards of validity and reliability;

1724 (4) the limitations of the data sources and analytic methodologies used to develop
1725 provider profiles shall be clearly identified and acknowledged, including, but not limited to, the
1726 appropriate and inappropriate uses of the data;

1727 (5) to the greatest extent possible, provider profiling initiatives shall use standard-
1728 based norms derived from widely accepted, provider-developed practice guidelines;

1729 (6) provider profiles and other information that have been compiled regarding
1730 provider performance shall be shared with providers under review prior to dissemination;
1731 provided, however, that opportunity for corrections and additions of helpful explanatory
1732 comments shall be provided prior to publication; and, provided, further, that such profiles shall

1733 only include data which reflect care under the control of the provider for whom such profile is
1734 prepared;

1735 (7) comparisons among provider profiles shall adjust for patient case-mix and
1736 other relevant risk factors and control for provider peer groups, when appropriate;

1737 (8) effective safeguards to protect against the unauthorized use or disclosure of
1738 provider profiles shall be developed and implemented;

1739 (9) effective safeguards to protect against the dissemination of inconsistent,
1740 incomplete, invalid, inaccurate or subjective profile data shall be developed and implemented;
1741 and

1742 (10) the quality and accuracy of provider profiles, data sources and methodologies
1743 shall be evaluated regularly.

1744 Section 9. (a) The center shall promulgate regulations to require that provider
1745 organizations registered under section 11 of chapter 6D report the data as it considers necessary
1746 in order to better protect the public's interest in monitoring the financial conditions,
1747 organizational structure, business practices and market share of each registered provider
1748 organization. The center may assess administrative fees on provider organizations in an amount
1749 to help defray the center's costs in complying with this section. The center may specify in
1750 regulations uniform reporting standards and reporting thresholds as it determines necessary.

1751 (b) The center shall require registered provider organizations to report following information
1752 annually: (1) organizational charts showing the ownership, governance and operational structure
1753 of the provider organization, including any clinical affiliations and community advisory boards;

1754 (2) the number of affiliated health care professional full-time equivalents by license type,
1755 specialty, name and address of principal practice location and whether the professional is
1756 employed by the organization; (3) the name and address of licensed facilities by license number,
1757 license type and capacity in each major service category; (4) a comprehensive financial
1758 statement, including information on parent entities and corporate affiliates as applicable, and
1759 including details regarding annual costs, annual receipts, realized capital gains and losses,
1760 accumulated surplus and accumulated reserves; (5) information on stop-loss insurance and any
1761 non-fee-for-service payment arrangements; (6) information on clinical quality, care coordination
1762 and patient referral practices; (7) information regarding expenditures and funding sources for
1763 payroll, teaching, research, advertising, taxes or payments-in-lieu-of-taxes and other non-clinical
1764 functions; (8) information regarding charitable care and community benefit programs; (9) for any
1765 risk-bearing provider organization, certificate from the division of insurance under chapter 176U;
1766 and (10) such other information as the center considers appropriate as set forth in the center's
1767 regulations; provided, however, that the center shall coordinate with the commission and the
1768 division of insurance to obtain information directly from the commission and the division of
1769 insurance where available. The center may, in consultation with the division of insurance and
1770 the commission, merge similar reporting requirements where appropriate.

1771 (c) Annual reporting shall be in a form provided by the center. The center shall promulgate
1772 regulations that define criteria for waivers from certain annual reporting requirements of this
1773 section. Criteria for waivers may include operational size of the provider organization, the
1774 provider organization's annual net patient service revenue, the degree of risk assumed by the
1775 provider organization, and other criteria as the center considers appropriate.

1776 (d) Notwithstanding the annual reporting requirements of this section, the commission may
1777 require in writing, at any time, additional information reasonable and necessary to determine the
1778 financial condition, organizational structure, business practices or market share of a registered
1779 provider organization.

1780 Section 10.(a) The center shall promulgate regulations necessary to ensure the uniform
1781 reporting of information from private and public health care payers, including third-party
1782 administrators, that enables the center to analyze: (1) changes over time in health insurance
1783 premium levels; (2) changes in the benefit and cost-sharing design of plans offered by these
1784 payers; (3) changes in measures of plan cost and utilization; provided that this analysis shall
1785 facilitate comparison among plans and between public and private payers; and (4) changes in
1786 type of payment methods implemented by payers and the number of members covered by
1787 alternative payment methodologies; provided, however, that this analysis shall facilitate
1788 comparison among plans and plan types, including the self-insured. The center shall adopt
1789 regulations to require private and public health care payers to submit claims data, member data
1790 and provider data to develop and maintain a database of health care claims data under this
1791 chapter.

1792 (b) The center shall require the submission of data and other information from each
1793 private health care payer offering small or large group health plans including, but not limited to:
1794 (1) average annual individual and family plan premiums for each payer's most popular plans for
1795 a representative range of group sizes, as further determined in regulations, and average annual
1796 individual and family plan premiums for the lowest cost plan in each group size that meets the
1797 minimum standards and guidelines established by the division of insurance under section 8H of
1798 chapter 26; (2) information concerning the actuarial assumptions that underlie the premiums for

1799 each plan; (3) summaries of the plan and network designs for each plan, including whether
1800 behavioral, substance use disorder and mental health or other specific services are carved-out
1801 from any plans; (4) information concerning the medical and administrative expenses, including
1802 medical loss ratios for each plan, using a uniform methodology and collected under section 21 of
1803 chapter 176O; (5) information concerning the payer's current level of reserves and surpluses; (6)
1804 information on provider payment methods and levels; (7) health status adjusted total medical
1805 expenses by registered provider organization, provider group and local practice group and zip
1806 code calculated according to the method established under section 51 of chapter 288 of the acts
1807 of 2010; (8) relative prices paid to every hospital, registered provider organization, physician
1808 group, ambulatory surgical center, freestanding imaging center, mental health facility,
1809 rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by
1810 type of provider, with hospital inpatient and outpatient prices listed separately and product type,
1811 including health maintenance organization and preferred provider organization products and
1812 determined using the method established under section 52 of chapter 288 of the acts of 2010; (9)
1813 hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform
1814 methodology; (10) the annual rate of growth, stated as a percentage, of the average relative price
1815 by provider type and product type for the payer's participating health care providers, whether
1816 that rate exceeds the rate of growth of the applicable producer price index as reported by the
1817 United States Bureau of Labor Statistics and identified by the commissioner of insurance and
1818 whether that rate exceeds the rate of growth in projected economic growth benchmark
1819 established under section 7H½ of chapter 29; and (11) a comparison of relative prices for the
1820 payer's participating health care providers by provider type which shows the average relative
1821 price, the extent of variation in price, stated as a percentage, and identifies providers who are

1822 paid more than 10 per cent, 15 per cent and 20 per cent above and more than 10 per cent, 15 per
1823 cent and 20 per cent below the average relative price.

1824 (c) The center shall require the submission of data and other information from public
1825 health care payers including, but not limited to: (1) average premium rates for health insurance
1826 plans offered by public payers and information concerning the actuarial assumptions that
1827 underlie these premiums; (2) average annual per-member per-month payments for enrollees in
1828 MassHealth primary care clinician and fee for service programs; (3) summaries of plan and
1829 network designs for each plan or program, including whether behavioral, substance use disorder
1830 and mental health or other specific services are carved-out from any plans; (4) information
1831 concerning the medical and administrative expenses, including medical loss ratios for each plan
1832 or program; (5) where appropriate, information concerning the payer's current level of reserves
1833 and surpluses; (6) information on provider payment methods and levels, including information
1834 concerning payment levels to each hospital for the 25 most common medical procedures
1835 provided to enrollees in these programs, in a form that allows payment comparisons between
1836 Medicaid programs and managed care organizations under contract to the office of Medicaid; (7)
1837 health status adjusted total medical expenses by registered provider organization, provider group
1838 and local practice group and zip code calculated according to the method established under
1839 section 51 of chapter 288 of the acts of 2010; and (8) relative prices paid to every hospital,
1840 registered provider organization, physician group, ambulatory surgical center, freestanding
1841 imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home
1842 health provider in the payer's network, by type of provider, with hospital inpatient and outpatient
1843 prices listed separately, and product type and determined using the method established under
1844 section 52 of chapter 288 of the acts of 2010; (9) hospital inpatient and outpatient costs,

1845 including direct and indirect costs, according to a uniform methodology; () the annual rate of
1846 growth, stated as a percentage, of the average relative price by provider type and product type
1847 for the payer's participating health care providers, whether that rate exceeds the rate of growth of
1848 the applicable producer price index as reported by the United States Bureau of Labor Statistics
1849 and identified by the commissioner of insurance and whether that rate exceeds the rate of growth
1850 in projected economic growth benchmark established under section 7H½ of chapter 29; and (11)
1851 a comparison of relative prices for the payer's participating health care providers by provider
1852 type which shows the average relative price, the extent of variation in price, stated as a
1853 percentage and identifies providers who are paid more than 10 per cent, 15 per cent and 20 per
1854 cent above and more than 10 per cent, 15 per cent and 20 per cent below the average relative
1855 price.

1856 (d) The center shall require the submission of data and other information from public and
1857 private health care payers which utilize alternative payment contracts, including, but not limited
1858 to: (1) if applicable, the negotiated monthly or yearly budget for each alternative payment
1859 contract in the current contract year; (2) any applicable measures of provider performance in
1860 such alternative payment contracts; and (3) if applicable, the average negotiated monthly or
1861 yearly budget weighted by member months for each geographic region of the commonwealth as
1862 further defined in regulations promulgated by the center.

1863 For purposes of this subsection, payers shall report the negotiated budget assuming a
1864 neutral health status score of 1.0 using an industry accepted health status adjustment tool and
1865 shall, if applicable, separately report the budget allowances for: all medical and behavioral,
1866 substance use disorder and mental health care at both in and out-of-network providers; pharmacy
1867 coverage allowance; administrative expenses such as data analytics, health information

1868 technology, clinical program development and other program management fees; the purchase of
1869 reinsurance or stop-loss; and quality bonus monies, unit cost adjustments or other special
1870 allowances as may be required in regulations promulgated by the center. If out-of-network care,
1871 behavioral, substance use disorder and mental health, stop-loss insurance or any other clinical
1872 services are carved out of any global budget, bundled payments or other alternative payment
1873 methodologies such that there is no allowance included in the budget for those services, payers
1874 shall report actual claims costs of these items on a per member per month basis for the year
1875 immediately prior to the current contract year.

1876 (e) Except as specifically provided otherwise by the center or under this chapter, insurer
1877 data collected by the center under this section shall not be a public record under clause Twenty-
1878 sixth of section 7 of chapter 4 or under chapter 66.

1879 Section 11. The center shall ensure the timely reporting of information required under
1880 sections 8, 9 and 10. The center shall notify payers, providers and provider organizations of any
1881 applicable reporting deadlines. The center shall notify, in writing, a private health care payer,
1882 provider or provider organization, which has failed to meet a reporting deadline and that failure
1883 to respond within 2 weeks of the receipt of the notice may result in penalties. The center may
1884 assess a penalty against a private payer, provider or provider organization that fails, without just
1885 cause, to provide the requested information within 2 weeks following receipt of the written
1886 notice required under this paragraph, of up to \$1,000 per week for each week of delay after the 2
1887 week period following the private payer's, provider's or provider organization's receipt of the
1888 written notice; provided, however, that the maximum annual penalty against a private payer,
1889 provider or provider organization under this section shall be \$50,000. Amounts collected under

1890 this section shall be deposited in the Healthcare Payment Reform Fund, established under section
1891 100 of 194 of the acts of 2011.

1892 Section 12. (a) The center shall be the sole repository for health care data collected under
1893 sections 8, 9 and 10. The center shall collect, store and maintain such data in a payer and
1894 provider claims database. The center shall acquire, retain and oversee all information technology,
1895 infrastructure, hardware, components, servers and employees necessary to carry out this section.
1896 All other agencies, authorities, councils, boards and commissions of the commonwealth seeking
1897 health care data that is collected under this section shall, whenever feasible, utilize the data
1898 before requesting data directly from health care providers and payers. In order to ensure patient
1899 data confidentiality, the center shall not contract or transfer the operation of the database or its
1900 functions to a third-party entity, nonprofit organization or governmental entity; provided,
1901 however, that the center may enter into interagency services agreements for transfer and use of
1902 the data.

1903 The center shall, to the extent feasible, make data in the payer and provider claims
1904 database available to payers and providers in real-time; provided, however, that all data-sharing
1905 complies with applicable state and federal privacy laws The center may charge a fee for access to
1906 the data.

1907 To the maximum extent feasible, the center shall also make data available to health care
1908 consumers, on a timely basis and in an easily readable and understandable format, data on health
1909 care services they have personally received.

1910 (b) The center shall permit providers, provider organizations, public and private health
1911 care payers, government agencies and authorities and researchers access to de-identified data

1912 collected by the center for the purposes of lowering total medical expenses, coordinating care,
1913 benchmarking, quality analysis and other research, administrative or planning purposes,
1914 provided, however, that the data shall not include information that would allow the identification
1915 of the health information of an individual patient, except to the extent necessary for a
1916 government agency or authority to accomplish the public purposes for which access was given.
1917 The center shall also permit providers, provider organizations, and public and private health care
1918 payers access to data with patient identifiers solely for the purpose of carrying out treatment and
1919 coordinating care among providers. Access to data authorized under this section shall be deemed
1920 to comply with the requirements of chapter 66A. The center shall charge user fees sufficient to
1921 defray the center's cost of providing such access to non-governmental entities.

1922 Section 13. The center shall coordinate with the public health council and the boards of
1923 registration for health care providers to develop a uniform and interoperable electronic system of
1924 public reporting for providers as a condition of licensure. The uniform provider licensure
1925 reporting system shall include information designed for health resource planning and for analysis
1926 of market share by provider organization by primary service areas and dispersed service areas,
1927 including, but not limited to, reporting for each licensed provider its principal business locations;
1928 the categories of services provided; the provider organization with which the provider is
1929 affiliated for contracting purposes, or by which the provider is employed, if any; whether and to
1930 what extent the provider is practicing on license; and other factors as the center considers
1931 appropriate. The center may centralize the uniform provider licensure reporting system or create
1932 a central portal for public access to the uniform provider licensure information. The uniform
1933 provider licensure reporting system shall be accessible to other state agencies and authorities

1934 including, but not limited to, the commission, the executive office of health and human services,
1935 the department of public health and the office of Medicaid.

1936 Section 14. (a) The center shall develop the uniform reporting of a standard set of health
1937 care quality measures for each health care provider facility, medical group, or provider group in
1938 the commonwealth hereinafter referred to as the “standard quality measure set.”

1939 (b) The center shall convene a statewide advisory committee which shall recommend to
1940 the center a standard quality measure set. The statewide advisory committee shall consist of the
1941 executive director of the center or designee, who shall serve as the chairperson; the executive
1942 director of the group insurance commission or designee, the Medicaid director or designee; and 7
1943 representatives of organizations to be appointed by the governor, 1 of whom shall be a
1944 representative from an acute care hospital or hospital association, 1 of whom shall be a
1945 representative from a provider group or medical association or provider association, 1 of whom
1946 shall be a representative from a medical group, 2 of whom shall be representatives of private
1947 health plans, 1 of whom shall be a representative from an employer association and 1 of whom
1948 shall be a representative from a health care consumer group.

1949 (c) In developing its recommendation of the standard quality measure set, the advisory
1950 committee shall, after consulting with state and national organizations that monitor and develop
1951 quality and safety measures, select from existing quality measures and shall not select quality
1952 measures that are still in development or develop its own quality measures. The committee shall
1953 annually recommend to the center any updates to the standard quality measure set on or before
1954 November 1. The committee may solicit for consideration and recommend other nationally
1955 recognized quality measures, including, but not limited to, recommendations from medical or

1956 provider specialty groups as to appropriate quality measures for that group’s specialty. At a
1957 minimum, the standard quality measure set shall consist of the following quality measures: (1)
1958 the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial
1959 infarction, congestive heart failure, pneumonia and surgical infection prevention; (2) the Hospital
1960 Consumer Assessment of Healthcare Providers and Systems survey; (3) the Healthcare
1961 Effectiveness Data and Information Set reported as individual measures and as a weighted
1962 aggregate of the individual measures by medical or provider group; and (4) the Ambulatory Care
1963 Experiences Survey. The standard quality measure set shall include outcome measures. The
1964 committee shall review additional appropriate outcome measures as they are developed.

1965 Section 15. (a) For the purposes of this section, the following words shall, unless the
1966 context clearly requires otherwise, have the following meanings:

1967 “Adverse event”, injury to a patient resulting from a medical intervention and not to the
1968 underlying condition of the patient.

1969 “Board”, the patient safety and medical errors reduction board.

1970 “Lehman center”, the Betsy Lehman center for patient safety and medical error reduction.

1971 “Incident”, an incident which, if left undetected or uncorrected, might have resulted in an
1972 adverse event.

1973 “Medical error”, the failure of medical management of a planned action to be completed
1974 as intended or the use of a wrong plan to achieve an outcome.

1975 “Patient safety”, freedom from accidental injury.

1976 (b) There shall be established within the center the Betsy Lehman center for patient safety
1977 and medical error reduction. The purpose of the Lehman center shall be to serve as a
1978 clearinghouse for the development, evaluation and dissemination, including, but not limited to,
1979 the sponsorship of training and education programs, of best practices for patient safety and
1980 medical error reduction. The Lehman center shall: (1) coordinate the efforts of state agencies
1981 engaged in the regulation, contracting or delivery of health care and those individuals or
1982 institutions licensed by the commonwealth to provide health care to meet their responsibilities
1983 for patient safety and medical error reduction; (2) assist all such entities to work as part of a total
1984 system of patient safety; and (3) develop appropriate mechanisms for consumers to be included
1985 in a statewide program for improving patient safety. The Lehman center shall coordinate state
1986 participation in any appropriate state or federal reports or data collection efforts relative to
1987 patient safety and medical error reduction. The Lehman center shall analyze available data,
1988 research and reports for information that would improve education and training programs that
1989 promote patient safety.

1990 (c) Within the Lehman center, there shall be established a patient safety and medical
1991 errors reduction board. The board shall consist of the secretary of health and human services, the
1992 executive director of the center, the director of consumer affairs and business regulations and the
1993 attorney general. The board shall appoint, in consultation with the advisory committee, the
1994 director of the Lehman center by a unanimous vote and the director shall, under the general
1995 supervision of the board, have general oversight of the operation of the Lehman center. The
1996 director may appoint or retain and remove expert, clerical or other assistants as the work of the
1997 Lehman center may require. The coalition for the prevention of medical errors shall serve as the
1998 advisory committee to the board. The advisory committee shall, at the request of the director,

1999 provide advice and counsel as it considers appropriate including, but not limited to, serving as a
2000 resource for studies and projects undertaken or sponsored by the Lehman center. The advisory
2001 committee may also review and comment on regulations and standards proposed or promulgated
2002 by the Lehman center, but the review and comment shall be advisory in nature and shall not be
2003 considered binding on the Lehman center.

2004 (d) The Lehman center shall develop and administer a patient safety and medical error
2005 reduction education and research program to assist health care professionals, health care facilities
2006 and agencies and the general public regarding issues related to the causes and consequences of
2007 medical error and practices and procedures to promote the highest standard for patient safety in
2008 the commonwealth. The Lehman center shall annually report to the governor and the general
2009 court relative to the feasibility of developing standards for patient safety and medical error
2010 reduction programs for any state department, agency, commission or board to reduce medical
2011 errors, and the statutory responsibilities of the commonwealth, for the protection of patients and
2012 consumers of health care together with recommendations to improve coordination and
2013 effectiveness of the programs and activities.

2014 (e) The Lehman center shall (1) identify and disseminate information about evidence-
2015 based best practices to reduce medical errors and enhance patient safety; (2) develop a process
2016 for determining which evidence-based best practices should be considered for adoption; (3) serve
2017 as a central clearinghouse for the collection and analysis of existing information on the causes of
2018 medical errors and strategies for prevention; and (4) increase awareness of error prevention
2019 strategies through public and professional education. The information collected by the Lehman
2020 center or reported to the Lehman center shall not be a public record as defined in section 7 of
2021 chapter 4, shall be confidential and shall not be subject to subpoena or discovery or introduced

2022 into evidence in any judicial or administrative proceeding, except as otherwise specifically
2023 provided by law.

2024 (f) The Lehman center shall report annually to the general court regarding the progress
2025 made in improving patient safety and medical error reduction. The Lehman center shall seek
2026 federal and foundation support to supplement state resources to carry out the Lehman center's
2027 patient safety and medical error reduction goals.

2028 Section 16. (a) The center shall publish an annual report based on the information
2029 submitted under sections 8, 9 and 10 concerning health care provider, provider organization and
2030 private and public health care payer costs and cost trends, section 13 of chapter 6D relative to
2031 market power reviews and section 15 relative to quality data. The center shall compare the costs
2032 and cost trends with the health care cost growth benchmark established by the health policy
2033 commission under section 9 of chapter 6D, analyzed by regions of the commonwealth, and shall
2034 detail: (1) baseline information about cost, price, quality, utilization and market power in the
2035 commonwealth's health care system; (2) cost growth trends for care provided within and outside
2036 of accountable care organizations and patient-centered medical homes; (3) cost growth trends by
2037 provider sector, including but not limited to, hospitals, hospital systems, non-acute providers,
2038 pharmaceuticals, medical devices and durable medical equipment; (4) factors that contribute to
2039 cost growth within the commonwealth's health care system and to the relationship between
2040 provider costs and payer premium rates; (5) the proportion of health care expenditures
2041 reimbursed under fee-for-service and alternative payment methodologies; (6) the impact of
2042 health care payment and delivery reform efforts on health care costs including, but not limited to,
2043 the development of limited and tiered networks, increased price transparency, increased
2044 utilization of electronic medical records and other health technology; (7) the impact of any

2045 assessments including, but not limited to, the health system benefit surcharge collected under
2046 section 68 of chapter 118E, on health insurance premiums; (8) trends in utilization of
2047 unnecessary or duplicative services, with particular emphasis on imaging and other high-cost
2048 services; (9) the prevalence and trends in adoption of alternative payment methodologies and
2049 impact of alternative payment methodologies on overall health care spending, insurance
2050 premiums and provider rates; (10) the development and status of provider organizations in the
2051 commonwealth including, but not limited to, acquisitions, mergers, consolidations and any
2052 evidence of excess consolidation or anti-competitive behavior by provider organizations; and
2053 (11) the impact of health care payment and delivery reform on the quality of care delivered in the
2054 commonwealth.

2055 As part of its annual report, the center shall report on price variation between health care
2056 providers, by payer and provider type. The center's report shall include: (1) baseline information
2057 about price variation between health care providers by payer including, but not limited to,
2058 identifying providers or provider organizations that are paid more than 10 per cent above or more
2059 than 10 per cent below the average relative price and identifying payers which have entered into
2060 alternative payment contracts that vary by more than 10 per cent; (2) the annual change in price
2061 variation, by payer, among the payer's participating providers; (3) factors that contribute to price
2062 variation in the commonwealth's health care system; (4) the impact of price variations on
2063 disproportionate share hospitals and other safety net providers; and (5) the impact of health
2064 reform efforts on price variation including, but not limited to, the impact of increased price
2065 transparency, increased prevalence of alternative payment contracts and increased prevalence of
2066 accountable care organizations and patient centered medical homes.

2067 The center shall publish and provide the report to health policy commission at least 30
2068 days before any hearing required under section 8 of chapter 6D. The center may contract with an
2069 outside organization with expertise in issues related to the topics of the hearings to produce this
2070 report.

2071 (b) The center shall participate in the annual hearing required by section 8 of chapter 6D
2072 and advise and assist the health policy commission in conducting such hearing including, but not
2073 limited to, identifying witnesses and examining and cross-examining providers, provider
2074 organizations and payers regarding any issues material to the subject of such hearings.

2075 (c) The center shall provide technical assistance to the health policy commission in
2076 compiling the annual report required by section 8 of chapter 6D including, but not limited to,
2077 providing access to any data collected by the center under section 8, 9 and 10 and providing
2078 analysis regarding spending trends and factors underlying the spending trends.

2079 Section 17. The attorney general may review and analyze any information submitted to
2080 the center under sections 8, 9 and 10 and the health policy commission under section 8 of chapter
2081 6D. The attorney general may require that any provider, provider organization, or payer produce
2082 documents, answer interrogatories and provide testimony under oath related to health care costs
2083 and cost trends, factors that contribute to cost growth within the commonwealth's health care
2084 system and the relationship between provider costs and payer premium rates. The attorney
2085 general shall keep confidential all nonpublic information and documents obtained under this
2086 section and shall not disclose the information or documents to any person without the consent of
2087 the provider or payer that produced the information or documents except in a public hearing
2088 under section 8 of chapter 6D, a rate hearing before the division of insurance or in a case brought

2089 by the attorney general, if the attorney general believes that such disclosure will promote the
2090 health care cost containment goals of the commonwealth and that the disclosure should be made
2091 in the public interest after taking into account any privacy, trade secret or anti-competitive
2092 considerations. The confidential information and documents shall not be public records and shall
2093 be exempt from disclosure under clause Twenty-sixth of section 7 of chapter 4 or section 10 of
2094 chapter 66.

2095 Section 18. The center shall perform ongoing analysis of data it receives under sections 8, 9 and
2096 10 to identify any payers, providers or provider organizations whose increase in health status
2097 adjusted total medical expense is considered excessive and who threaten the ability of the state to
2098 meet the health care cost growth benchmark established by the health care finance and policy
2099 commission under section 10 of chapter 6D. The center shall confidentially provide a list of the
2100 payers, providers and provider organizations to the health policy commission such that the
2101 authority may pursue further action under section 10 of chapter 6D.

2102 Section 19. The center shall review and comment upon all capital expenditure projects
2103 requiring a determination of need under section 25C of chapter 111, including, but not limited to,
2104 the availability and accessibility of services similar to those provided, or proposed to be
2105 provided, through the provider organization within its primary service areas and dispersed
2106 service areas; the provider organization's impact on competing options for the delivery of health
2107 care services within its primary service areas and dispersed service areas; less costly or more
2108 effective alternative financing methods for the projects; the immediate and long-term financial
2109 feasibility of the projects; the probable impact of the project on costs of and charges for services;
2110 and the availability of funds for capital and operating needs. The center may transmit to the
2111 department of public health its written recommendations on each project. The center shall

2112 appear and comment on any application for a determination of need where a public hearing is
2113 required under said section 25C of said chapter 111.

2114 Section 20. (a) The center, in consultation with commission, the executive office of
2115 health and human services, the department of public health and such other agencies or authorities
2116 as it deems appropriate, shall maintain a consumer health information website. The website shall
2117 contain information comparing the quality, price and cost of health care services. The website
2118 shall also provide information about provider and payer achievement of cost benchmarks and
2119 growth goals. The website may also contain general health care information as the center
2120 considers appropriate. The website shall be designed to assist consumers in making informed
2121 decisions regarding their medical care and informed choices among health care providers.
2122 Information shall be presented in a format that is understandable to the average consumer. The
2123 center shall publicize the availability of its website.

2124 (b) The website shall provide updated information on a regular basis, at least annually, and
2125 additional comparative quality, price and cost information shall be published as determined by
2126 the center. To the extent possible, the website shall include: (1) comparative price and cost
2127 information for the most common referral or prescribed services, as determined by the center,
2128 categorized by payer and listed by facility, provider, and provider organization or other
2129 groupings, as determined by the center ; (2) comparative quality information, as determined by
2130 the center, available by facility, provider, provider organization or any other provider grouping,
2131 as determined by the center, for each such service or category of service for which comparative
2132 price and cost information is provided; (3) general information related to each service or
2133 category of service for which comparative information is provided; (4) comparative quality
2134 information, as determined by the center, available by facility, provider, provider organization or

2135 other groupings, as determined by the center, that is not service-specific, including information
2136 related to patient safety and satisfaction; (5) data concerning healthcare-associated infections and
2137 serious reportable events reported under section 51H of chapter 111; (6) definitions of common
2138 health insurance and medical terms, including, but not limited to, those determined under
2139 sections 2715(g)(2) and (3) of the Public Health Service Act, so that consumers may compare
2140 health coverage and understand the terms of their coverage; (7) a list of health care provider
2141 types, including but not limited to primary care physicians, nurse practitioners and physician
2142 assistants, and what types of services they are authorized to perform in the commonwealth under
2143 applicable state and federal scope of practice laws; (8) factors consumers should consider when
2144 choosing an insurance product or provider group, including, but not limited to, provider network,
2145 premium, cost-sharing, covered services, and tiering; (9) patient decision aids, which are
2146 interactive, written or audio-visual tools that provide a balanced presentation of the condition and
2147 treatment or screening options, benefits and harms, with attention to the patient's preferences and
2148 values, and which may facilitate conversations between patients and their health care providers
2149 about preference-sensitive conditions or diseases such as chronic back pain, early stage of breast
2150 and prostate cancers, hip osteoarthritis, and cataracts; provided, however, that decision aids shall
2151 be made available on, but not be limited to, long-term care and supports and palliative care; (10)
2152 a list of provider services that are physically and programmatically accessible for people with
2153 disabilities; and (11) descriptions of standard quality measures, as determined by the center.

2154 (c) The center shall develop and adopt, on an annual basis, a reporting plan specifying
2155 the quality and cost measures to be included on the consumer health information website and the
2156 security measures used to maintain confidentiality and preserve the integrity of the data. In
2157 developing the reporting plan, the center, to the extent possible, shall collaborate with other

2158 organizations or state or federal agencies that develop, collect and publicly report health care
2159 quality and cost measures and the center shall give priority to those measures that are already
2160 available in the public domain. As part of the reporting plan, the center shall determine for each
2161 service the comparative information to be included on the consumer health information website.

2162 (d) In designing and maintaining the website, the center may conduct research regarding
2163 ease of use of the website by health care consumers, consult with organizations that represent
2164 health care consumers, and conduct focus groups that represent a cross section of health care
2165 consumers in the commonwealth, including low income consumers and consumers with limited
2166 literacy. The website shall comply with the Americans with Disabilities Act.

2167 Section 21. The center shall establish a continuing program of investigation and study of
2168 the uninsured and underinsured in the commonwealth, including the health insurance needs of
2169 the residents of the geographically isolated or rural areas of the commonwealth. Said continuing
2170 investigation and study shall examine the overall impact of programs developed by the center
2171 and the division of medical assistance on the uninsured, the underinsured and the role of
2172 employers in assisting their employees in affording health insurance.

2173 Section 22. (a) Any provider of health care services that receives reimbursement or
2174 payment for treatment of injured workers under chapter 152 and any provider of health care
2175 services other than an acute or non-acute hospital that receives reimbursement or payment from
2176 any governmental unit for general health supplies, care and rehabilitative services and
2177 accommodations, shall, as a condition of such reimbursement or payment: (1) permit the
2178 executive director, or the executive director's designated representative and the attorney general
2179 or a designee, to examine such books and accounts as may reasonably be required for the center

2180 to perform its duties; (2) file with the executive director from time to time or on request, such
2181 data, statistics, schedules or other information as the center may reasonably require, including
2182 outcome data and such information regarding the costs, if any, of the provider for research in the
2183 basic biomedical or health delivery areas or for the training of health care personnel which are
2184 included in the provider's charges to the public for health care services, supplies and
2185 accommodations; and (3) accept reimbursement or payment at the rates established by the
2186 secretary of health and human services or a governmental unit designated by the executive
2187 office, subject to a right of appeal under section 13E of chapter 118E, as discharging in full any
2188 and all obligations of an eligible person and the governmental unit to pay, reimburse or
2189 compensate the provider of health care services in any way for general health supplies, care and
2190 rehabilitative services or accommodations provided.

2191 (b) Any provider of health care services that knowingly fails to file with the center data,
2192 statistics, schedules or other information required under this section or by any regulation
2193 promulgated by the center or knowingly falsifies the same shall be punished by a fine of not less
2194 than \$100 nor more than \$500.

2195 (c) If, upon application by the center or its designated representative, the superior court
2196 upon summary hearing determines that a provider of health care services has, without justifiable
2197 cause, refused to permit any examination or to furnish information, as required in this section; it
2198 shall issue an order directing all governmental units to withhold payment for general health
2199 supplies, care and rehabilitative services and accommodations to such provider of services until
2200 further order of the court.

2201 (d) In addition, the appropriate licensing authority may suspend or revoke, after an
2202 adjudicatory proceeding under chapter 30A, the license of any provider of health care services
2203 that knowingly fails to file with the center data, statistics, schedules or other information required
2204 by this section or by any regulation of the center or that knowingly falsifies the same.

2205 SECTION 20. Section 18 of chapter 15A of the General Laws, as appearing in the 2010
2206 Official Edition, is hereby amended by striking out, in line 14 and in line 36, the words “division
2207 of health care finance and policy”, each time they appear, and inserting in place thereof, in each
2208 instance, the following words:- commonwealth health insurance connector.

2209 SECTION 21. Section 8H of chapter 26 of the General Laws, as so appearing, is hereby
2210 amended by striking out, in lines 60, 64, 71 and 72 and 73 and 74 the words “division of health
2211 care finance and policy”, each time they appear, and inserting in place thereof, in each instance,
2212 the following words:- center for health information and analysis.

2213 SECTION 22. Said section 8H of said chapter 26, as so appearing, is hereby further
2214 amended by striking out, in lines 55, 56, 77 and 78 the words “uncompensated care pool under
2215 section 18 of chapter 118G” and inserting in place thereof, in each instance, the following
2216 words:- health safety net under chapter 118E .

2217 SECTION 23. Chapter 26 of the General Laws is hereby amended by inserting after
2218 section 8J, as so appearing, the following section:-

2219 Section 8K. The commissioner of insurance may implement and enforce applicable
2220 provisions of the federal Mental Health Parity and Addiction Equity Act, section 511 of Public
2221 Law 110-343, and applicable state mental health parity laws, including section 22 of chapter
2222 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and

2223 sections 4, 4B and 4M of chapter 176G of the General Laws, in regard to any carrier licensed
2224 under chapters 175, 176A, 176B and 176G.

2225 SECTION 24. Section 2000 of chapter 29 of the General Laws, as so appearing, is
2226 hereby amended by striking out, in line 6, the words “18B of chapter 118G” and inserting in
2227 place thereof the following words:- 18 of chapter 176Q.

2228 SECTION 25. Said section 2000 of said chapter 29, as so appearing, is hereby further
2229 amended by striking out, in line 16, the words “established by section 18 of chapter 118G”.

2230 SECTION 26. Section 2PPP of said chapter 29, as so appearing, is hereby amended by
2231 striking out, in lines 16 and 17, the words “section 35 of chapter 118G” and inserting in place
2232 thereof the following words:- section 65 of chapter 118E.

2233 SECTION 27. Section 2RRR of said chapter 29, as so appearing, is hereby amended by
2234 striking out clauses (a) to (c), inclusive, and inserting in place thereof the following 2 clauses:-
2235 (a) any federal financial participation received by the commonwealth as a result of expenditures
2236 funded by such assessments, and (b) any interest thereon.

2237 SECTION 28. Said chapter 29 is hereby further amended striking out section 2FFFF, inserted by
2238 section 60 of chapter 139 of the acts of 2012 and inserting in place thereof the following
2239 section:-

2240 Section 2FFFF. There is hereby established and set up on the books of the
2241 commonwealth a separate fund to be known as the Health Care Workforce Transformation Fund,
2242 hereinafter called the fund. The fund shall be administered by the secretary of labor and
2243 workforce development in consultation with the Health Care Workforce Advisory Board,

2244 established in subsection (b) ; The secretary shall make expenditures from the Health Care
2245 Workforce Transformation Fund, without further appropriation; provided, however, that not
2246 more than 10 per cent of the amount held in the fund in any 1 year shall be used by the secretary
2247 for the combined cost of program administration, technical assistance to grantees and program
2248 evaluation. The secretary may contract with any appropriate entity to administer the fund or any
2249 portion therein.

2250 (b) There shall be a Health Care Workforce Trust Fund Advisory Board constituted to
2251 make recommendations to the director secretary concerning the administration and allocation of
2252 the fund and establishing evaluation criteria.

2253 The board shall consist of the following members: the secretary of labor and workforce
2254 development who shall serve as chairperson; the executive director of the commission or a
2255 designee; the commissioner of public health or a designee, and no more than 13 members who
2256 shall be appointed by the secretary and who shall reflect a broad distribution of diverse
2257 perspectives on the health care system and health care workforce needs, including health care
2258 providers, health care payers, health care employers, labor organizations, educational
2259 institutions, and consumer representatives.

2260 (c) The comptroller shall annually transfer not less than 20 per cent of available funds in
2261 the fund to the department of public health, without requiring the approval of the secretary of
2262 labor and workforce development, to be expended on the following programs:

2263 (1) The health care workforce loan repayment program, established under section 25N of
2264 chapter 111, as administered by the healthcare workforce center;

2265 (2) The primary care residency grant program, established under section 25N ½ of
2266 chapter 111;

2267 (3) a primary care workforce development and loan forgiveness grant program at
2268 community health centers, established under section 25N ¾ of chapter 111.

2269 The secretary may also designate up to 10 per cent of available funds to be transferred by
2270 the comptroller to the Massachusetts Nursing and Allied Health Workforce Development Trust
2271 Fund established in section 33 of chapter 305 of the acts of 2008 to develop and support
2272 strategies that increase the number of public higher education faculty members and students who
2273 participate in programs that support careers in fields related to nursing and allied health. The
2274 secretary shall only designate funds for this purpose to the extent that the Massachusetts Nursing
2275 and Allied Health Workforce Development Trust Fund does not receive adequate funding in the
2276 annual appropriations bill approved by the general court.

2277 (d) Remaining monies from the fund shall be expended on programs that have 1 or more
2278 of the following purposes, with a focus on aligning expenditures with industry needs:

2279 (1) support the development and implementation of programs to enhance health
2280 care worker retention rates;

2281 (2) address critical health care workforce shortages;

2282 (3) improve employment in the health care industry for low-income individuals
2283 and low-wage workers;

2284 (4) provide training, educational, or career ladder services for currently employed
2285 or unemployed health care workers who are seeking new positions or responsibilities within the
2286 health care industry;

2287 (5) provide training or educational services for health care workers in emerging
2288 fields of care delivery models; or

2289 (6) fund rural health rotation programs, rural health clerkships, and rural health
2290 preceptorships at medical and nursing schools to expose students to practicing in rural and small
2291 town communities.

2292 (e) The secretary shall establish a competitive grant process for funds expended on
2293 programs under subsection (d). Eligible applicants shall include: employers and employer
2294 associations; local workforce investment boards; labor organizations; joint labor-management
2295 partnerships; community-based organizations; institutions of higher education; vocational
2296 education institutions; one-stop career centers; local workforce development entities; and any
2297 partnership or collaboration between eligible applicants. Expenditures from the fund for such
2298 purposes shall complement and not replace existing local, state, private, or federal funding for
2299 training and educational programs. All approved activities funded through the fund shall support
2300 the commonwealth's efforts to meet the health care cost growth benchmark established under
2301 section 9 of chapter 6D.

2302 (f) A grant proposal submitted under subsection (e) shall include, but not be limited to:

2303 (1) a plan that defines specific goals for health care workforce training and
2304 educational improvements;

2305 (2) the evidence-based programs the applicant shall use to meet the goals;

2306 (3) a budget necessary to implement the plan, including a detailed description of
2307 any funding or in-kind contributions the applicant or applicants will be providing in support of
2308 the proposal;

2309 (4) any other private funding or private sector participation the applicant
2310 anticipates in support of the proposal; and

2311 (5) the anticipated number of individuals who would receive a benefit due to the
2312 implementation of the plan.

2313 Priority may be given to proposals that target areas of critical labor needs for the health
2314 care industry or that are projected to be critical labor needs of the health care industry in the near
2315 future, consistent with the state health plan developed under section 16T of chapter 6A.

2316 Priority may also be given to proposals that target geographic areas with specific health care
2317 workforce needs or that target geographic areas with unemployment levels higher than the state
2318 average. If no proposals were offered in areas of particular need, the secretary may provide
2319 technical assistance and planning grant funding directly to eligible applicants in order to develop
2320 grant proposals.

2321 The secretary shall, in consultation with the Health Care Workforce Advisory Board,
2322 develop guidelines for an annual review of the progress being made by each grantee. Each
2323 grantee shall participate in any evaluation or accountability process implemented by or
2324 authorized by the secretary.

2325 (g) There shall be credited to the fund all monies payable pursuant to (1) funds that are
2326 paid to the health care workforce loan repayment program, established under section 25N of
2327 chapter 111 as a result of a breach of contract and private funds contributed from other sources;
2328 and (2) any revenue from appropriations or other monies authorized by the general court and
2329 specifically designated to be credited to the fund, and any gifts, grants, private contributions,
2330 investment income earned on the fund's assets and all other sources. Money remaining in the
2331 fund at the end of a fiscal year shall not revert to the General Fund and shall be available for
2332 expenditure in the following fiscal year.

2333 (h) The fund shall supplement and not replace existing publically-financed health care
2334 workforce development programs.

2335 (i) The secretary shall annually report on its strategy for administration and allocation of
2336 the fund, including relevant evaluation criteria, and short-term and long-term programmatic and
2337 policy recommendations to improve workforce performance, and on expenditures from fund.
2338 The report shall include, but shall not be limited to: (1) the revenue credited to the fund; (2) the
2339 amount of fund expenditures attributable to administrative costs; (3) an itemized list of the funds
2340 expended through the competitive grant process, loan repayment program, and primary care
2341 residency program, and a description of the grantee activities; and; (4) the results of the
2342 evaluation of the effectiveness of the activities funded through grants. The report shall be
2343 provided to the secretary of administration and finance, the chairpersons of the house and senate
2344 committees on ways and means, the joint committee on public health, the joint committee on
2345 health care financing and the joint committee on labor and workforce development and shall be
2346 posted on the executive office of labor and workforce development's website.

2347 (j) The secretary center shall promulgate regulations necessary to carry out this section.

2348 SECTION 29. Said chapter 29 is hereby further amended by inserting after section

2349 2FFFF the following section:—

2350 Section 2GGGG. (a) There shall be established and set upon the books of the
2351 commonwealth a separate fund to be known as the Distressed Hospital Trust Fund to be
2352 expended, without further appropriation, by the health policy commission. The fund shall consist
2353 public and private sources such as gifts, grants and donations, interest earned on such revenues
2354 and any funds provided from other sources.

2355 The board of the health policy commission, as trustee, shall administer the fund and shall
2356 make expenditures from the fund consistent with this section; provided, however, that not more
2357 than 10 per cent of the amounts held in the fund in any 1 year shall be used by the commission
2358 for the combined cost of program administration, technical assistance to grantees or program
2359 evaluation.

2360 (b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall
2361 not revert to the General Fund and shall be available for expenditure in the following fiscal year.

2362 (c) All expenditures from the Distressed Hospital Trust Fund shall support the state's
2363 efforts to meet the health care cost growth benchmark established in section 9 of chapter 6D and
2364 shall be consistent with any activities funded by the e-Health Institute, the Healthcare Payment
2365 Reform Fund, and any delivery system transformation initiative funds authorized by the federal
2366 government. All expenditures shall have 1 or more of the following purposes: (1) to improve
2367 and enhance the ability of community hospitals to serve populations efficiently and effectively;
2368 (2) to advance the adoption of health information technology, including interoperable electronic

2369 health records systems; (3) to accelerate the ability to electronically exchange information with
2370 other providers in the community to ensure continuity of care; (4) to support infrastructure
2371 investments necessary for the transition to alternative payment methodologies, including
2372 technology investments in data analysis functions and performance management programs,
2373 including systems to promote provider price transparency, necessary to aggregate and analyze
2374 clinical data on a population level; (5) to aid in the development of care practices and other
2375 operational standards necessary for certification as an ACO under section 15 and 6D; and (6) to
2376 improve the affordability and quality of care.

2377 (d) The commission shall annually award a grant by a competitive grant process to
2378 qualified acute hospitals. To be eligible to receive a grant under this subsection, a qualified acute
2379 hospital shall not include: (1) any hospital that is a teaching hospital; (2) any hospital whose
2380 relative prices are above the statewide median relative price, as determined by the center for
2381 health information analysis; or, (3) a for-profit hospital or a hospital that is part of a for-profit
2382 hospital system.

2383 (e) A grant proposal submitted under subsection (d) shall include, but not be limited to:
2384 (1) a plan that defines specific goals for improving the efficiency and affordability of hospital
2385 care over a multi-year period; (2) the evidence-based programs the applicant shall use to meet
2386 the goals; (3) a budget necessary to implement the plan, including a detailed description of any
2387 funding or in-kind contributions the applicant or applicants will be providing in support of the
2388 proposal; (4) a plan for sustaining any investments after the expiration of grant funds; and (5)
2389 any other private funding or private sector participation the applicant anticipates in support of the
2390 proposal.

2391 In reviewing the grant applications, the commission shall consider, among other factors:
2392 (1) the financial health of the qualified acute hospital and the demonstrated need for investment,
2393 taking into account all resources available to the particular provider including the relationship or
2394 affiliation of the particular provider to a health care delivery system and the capacity of the
2395 system to provide financial support for the acute hospital; (2) the anticipated return on
2396 investment, as measured by improved health care coordination and a reduction in health care
2397 costs; (3) whether the investment will support innovative health care delivery and payment
2398 models as identified by the health care policy commission; and (4) geographic need and
2399 population need. In assessing financial health, the commission shall, in consultation with the
2400 center for health information and analysis, take into account days cash on hand, net working
2401 capital and earnings before income tax, payer mix, uncompensated care, and depreciation and
2402 amortization, and access to working capital. If the commission determines that no suitable
2403 proposals have been received, such that the specific needs remain unmet, the commission may
2404 work directly with qualified acute hospitals to develop grant proposals.

2405 (f) All approved grants shall contain a limit on the amount an acute hospital may spend
2406 on administrative or overhead spending related to the approved project, as determined by the
2407 commission.

2408 (g) Funding for all approved interoperable health information technology projects for
2409 qualified acute hospitals shall be prioritized from any available funds in the Distressed Hospital
2410 Trust Fund before any funds from the e-Health Institute Trust Fund may be utilized.

2411 (h) As a condition of an award, the commission may require a qualified hospital to agree
2412 to an independent financial and operational audit to recommend steps to increase sustainability
2413 and efficiency of the acute hospital.

2414 (i) The commission shall develop guidelines for an annual review of the progress being
2415 made by each grantee. Each grantee shall participate in any evaluation or accountability process
2416 implemented or authorized by the commission. In the event that any recipient of grant monies
2417 from this trust does not utilize funding in a manner consistent with the approved grant
2418 application, the recipient shall be required to repay to the commission all or some portion, as
2419 determined by the commission, of the grant funds previously provided to the recipient under this
2420 section.

2421 (j) The commission shall, annually on or before January 31, report on expenditures from
2422 the Distressed Hospital Trust Fund. The report shall include, but not be limited to: (1) the
2423 revenue credited to the fund; (2) the amount of fund expenditures attributable to the
2424 administrative costs of the commission; (3) an itemized list of the funds expended through the
2425 competitive grant process and a description of the grantee activities; and (4) the results of the
2426 evaluation of the effectiveness of the activities funded through grants. The report shall be
2427 provided to the chairpersons of the house and senate committees on ways and means and the
2428 joint committee on health care financing and shall be posted on the commission's website.

2429 (k) The commission shall promulgate regulations necessary to carry out this section.

2430 SECTION 30. Said chapter 29 is hereby further amended by inserting after section 7H
2431 the following section:-

2432 Section 7H ½. (a) As used in this section the following words shall, unless the context
2433 clearly requires otherwise, have the following meanings:

2434 “Actual economic growth benchmark,” the actual annual percentage change in the per
2435 capita state’s gross state product, as established by the secretary of administration and finance
2436 under subsection (c).

2437 “Growth rate of potential gross state product”, the long-run average growth rate of the
2438 commonwealth’s economy, excluding fluctuations due to the business cycle.

2439 (b) On or before January 15, the secretary of administration and finance shall meet with
2440 the house and senate committees on ways and means and shall jointly develop a growth rate of
2441 potential gross state product for the ensuing calendar year which shall be agreed to by the
2442 secretary and the committees. In developing a growth rate of potential gross state product the
2443 secretary and the committees, or subcommittees of the committees, may hold joint hearings on
2444 the economy of the commonwealth; provided, however, that in the first year of the term of office
2445 of a governor who has not served in the preceding year, the parties shall agree to the growth rate
2446 of potential gross state product k not later than January 31 of that year. The secretary and the
2447 committees may agree to incorporate this hearing into any consensus tax revenue forecast
2448 hearing held under section 5B. The growth rate of potential gross state product shall be included
2449 with the consensus tax revenue forecast joint resolution under said section 5B and placed before
2450 the members of the general court for their consideration. The joint resolution, if passed by both
2451 branches of the general court, shall establish the growth rate of potential gross state product to be
2452 used by the health policy commission to establish the health care cost growth benchmark under
2453 section 9 of chapter 6D.

2454 (c) Not later than September 15 of each year, the secretary shall report the actual
2455 economic growth benchmark for the previous calendar year, based on the best information
2456 available at the time. The information shall be provided to the health policy commission
2457 established under chapter 6D.

2458 SECTION 31. Section 1 of chapter 29D of the General Laws, as appearing in the 2010
2459 Official Edition, is hereby amended by striking out, in line 13, the words “25 and 26 of chapter
2460 118G” and inserting in place thereof the following words:- 63 of chapter 118E.

2461 SECTION 32. Section 3 of said chapter 29D, as so appearing, is hereby amended by
2462 striking out, in line 18, the words “25 and 26 of chapter 118G” and inserting in place thereof the
2463 following words:- 63 of chapter 118E.

2464 SECTION 33. Said section 3 of said chapter 29D, as so appearing, is hereby further
2465 amended by striking out, in line 22, the words “25 and 26 of said chapter 118G” and inserting in
2466 place thereof the following words:- 63 of said chapter 118E.

2467 SECTION 34. Section 2 of chapter 32A of the General Laws, as so appearing, is hereby
2468 amended by inserting after paragraph (h) the following paragraph:-

2469 (h 1/2) “Primary care provider”, a health care professional qualified to provide general
2470 medical care for common health care problems who; (1) supervises, coordinates, prescribes, or
2471 otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and
2472 (3) maintains continuity of care within the scope of practice.

2473 SECTION 35. Section 22 of said chapter 32A, as so appearing, is hereby amended by
2474 striking out, in line 36, the word “physician” and inserting in place thereof the following word:-
2475 provider.

2476 SECTION 36. Said chapter 32A is hereby amended by adding the following section:-

2477 Section 27. The commission shall require any carriers or third party administrators with whom it
2478 contracts to provide a toll-free telephone number and website that enables consumers to request
2479 and obtain from the carrier or third party administrator, within 2 working days, the estimated or
2480 maximum allowed amount or charge for a proposed admission, procedure or service and the
2481 estimated amount the insured will be responsible to pay for a proposed admission, procedure or
2482 service that is a medically necessary covered benefit, based on the information available to the
2483 carrier or third party administrator at the time the request is made, including any facility fee,
2484 copayment, deductible, coinsurance or other out of pocket amount for any covered health care
2485 benefits; provided, that the insured shall not be required to pay more than the disclosed amounts
2486 for the covered health care benefits that were actually provided; provided, however, that nothing
2487 in this section shall prevent carriers from imposing cost sharing requirements disclosed in the
2488 insured’s evidence of coverage for unforeseen services that arise out of the proposed admission,
2489 procedure or service; and provided further, that the carrier shall alert the insured that these are
2490 estimated costs, and that the actual amount the insured will be responsible to pay may vary due
2491 to unforeseen services that arise out of the proposed admission, procedure or service.

2492 SECTION 37. Section 27 of chapter 32A, as inserted by section 36, is hereby amended
2493 by striking out the words “within 2 working days” and inserting in place thereof the following
2494 words:- “in real time”.

2495 SECTION 38. Chapter 40J of the General Laws is hereby amended by striking out
2496 sections 6D and 6E, as so appearing, and inserting in place thereof the following 2 sections:-

2497 Section 6D. (a) There shall be established an institute for health care innovation,
2498 technology and competitiveness, to be known as the Massachusetts e-Health Institute. The
2499 executive director of the corporation shall appoint a qualified individual to serve as the director
2500 of the institute, who shall be an employee of the corporation, report to the executive director and
2501 manage the affairs of the institute. The institute shall advance the dissemination of health
2502 information technology across the commonwealth, including the deployment of interoperable
2503 electronic health records systems in all health care provider settings that are networked through a
2504 statewide health information exchange. The institute shall (1) conduct the regional extension
2505 center program for the coordination and implementation of electronic health records systems by
2506 providers; (2) fulfill its current and any future contract obligations with the Office of Medicaid to
2507 administer specific operational components of the MassHealth electronic health records incentive
2508 program; and (3) develop a plan to complete the implementation of electronic health records
2509 systems by all providers in the commonwealth.

2510 (b) The institute, in consultation with the health information technology council
2511 established under section 2 of chapter 118I of the General Laws, shall advance the dissemination
2512 of health information technology and support the state's efforts in meeting the health care cost
2513 growth benchmark established under section 9 of chapter 6D by: (1) facilitating the
2514 implementation and use of interoperable electronic health records systems by health care
2515 providers in order to improve health care delivery and coordination, reduce unwarranted
2516 treatment variation, eliminate wasteful paper-based processes, help facilitate chronic disease
2517 management initiatives and establish transparency; (2) supporting the council in the creation and

2518 maintenance of a statewide interoperable electronic health information exchange that allows
2519 individual health care providers in all health care settings to exchange patient health information
2520 with other providers;(3) identifying and promoting an accelerated dissemination in the
2521 commonwealth of emerging health care technologies that have been developed and employed
2522 and that are expected to improve health care quality and lower health care costs, but that have not
2523 been widely implemented in the commonwealth, including, but not limited to, evidence-based
2524 clinical decision support and image exchange tools for advanced diagnostic imaging services; (4)
2525 facilitating health care providers in achieving and maintaining compliance with the standards for
2526 meaningful use, beyond stage 1, established by regulation by the United States Department of
2527 Health and Human Services under the Health Information Technology for Economic and Clinical
2528 Health Act and referred to in this section as “meaningful use”; and (5) promoting to patients,
2529 providers and the general public, a broad understanding of the benefits of interoperable
2530 electronic health records systems for care delivery, care coordination, improved quality and
2531 ultimately greater cost efficiency in the health care delivery system.

2532 (c) The institute director shall prepare and annually update a statewide electronic health
2533 records plan. Each plan shall contain a budget for the application of funds from the e-Health
2534 Institute Fund for use in implementing each plan. The institute director shall submit the plans and
2535 updates, and associated budgets, to the council for its review and comment. Each plan and the
2536 associated budget shall be subject to approval of the board following review by the council. Each
2537 plan shall be consistent with the statewide health information exchange plan developed by the
2538 health information technology council under section 4 of chapter 118I.

2539 Components of each plan, as updated, shall be community-based implementation plans
2540 that assess a municipality’s or region’s readiness to implement and use electronic health record

2541 systems and an interoperable electronic health records network within the referral market for a
2542 defined patient population. Each implementation plan shall address the development,
2543 implementation and dissemination of interoperable electronic health records systems among
2544 health care providers in the community or region, particularly providers, such as community
2545 health centers and community-based behavioral health, substance use disorder and mental health
2546 care providers that serve underserved populations, including, but not limited to, racial, ethnic and
2547 linguistic minorities, uninsured persons and areas with a high proportion of public payer care.

2548 Each plan as updated shall: (1) allow seamless, secure electronic exchange of health
2549 information among health care providers, health plans and other authorized users; (2) provide
2550 consumers with secure, electronic access to their own health information; (3) meet all applicable
2551 federal and state privacy and security requirements, including requirements imposed by 45
2552 C.F.R. §§ 160, 162 and 164; (4) meet standards for interoperability adopted by the institute;
2553 provided that the standards are consistent with the statewide health information exchange plan
2554 developed by the health information technology council under section 5 of chapter 118I ; (5)
2555 give patients the option of allowing only designated health care providers to disseminate their
2556 individually identifiable information; (6) provide public health reporting capability as required
2557 under state law; (7) support any activities funded by the Healthcare Payment Reform Fund; and
2558 (8) allow reporting of health information other than identifiable patient health information for
2559 purposes of such activities as the secretary of health and human services may consider necessary.

2560 (d) The corporation may contract with implementing organizations to: (1) facilitate a
2561 public-private partnership that includes representation from hospitals, physicians and other
2562 health care professionals, health insurers, employers and other health care purchasers, health data
2563 and service organizations and consumer organizations; (2) provide resources and support to

2564 recipients of grants awarded under subsection (f) to implement each program within the
2565 designated community pursuant to the implementation plan; (3) certify and disburse funds to
2566 subcontractors, when necessary; (4) provide technical assistance to facilitate successful practice
2567 redesign, adoption of electronic health records and utilization of care management strategies; (5)
2568 ensure that electronic health records systems are fully interoperable and secure and that sensitive
2569 patient information is kept confidential by exclusively utilizing electronic health records
2570 products that are certified by the Office of the National Coordinator under the federal Health
2571 Information Technology for Economic and Clinical Health Act; and (6) certify, with approval of
2572 the corporation, a group of subcontractors who shall provide the necessary hardware and
2573 software for system implementation. Before to the institute's issuing requests for proposals for
2574 contracts to be entered into under this section, the institute's director shall consult with the
2575 council with respect to the content of all such proposals. Nothing in this section shall be
2576 construed to provide the corporation or the institute any authority with respect to any contract
2577 relating to the development and implementation of the statewide health information exchange by
2578 the executive office of health and human services under section 2 of chapter 118I.

2579 (e) Funding for the institute's activities shall be through the e-Health Institute Fund,
2580 established in section 6E. The institute, in consultation with the health information technology
2581 council, shall develop mechanisms for funding health information technology, including a grant
2582 program to assist health care providers with costs associated with health information
2583 technologies, including electronic health records systems, and coordinated with other electronic
2584 health records projects seeking federal reimbursement. Providers eligible for receipt of amounts
2585 from the Fund shall be limited to (1) any individual or institutional provider of health care
2586 services that is not in a category of individual or institutional provider eligible to receive

2587 Medicare or Medicaid incentive payments under the federal Health Information Technology for
2588 Economic and Clinical Health Act, such payments being referred to in this subsection as
2589 “incentive payments,” and that lack access, as reasonably determined by the director of the
2590 institute, to resources needed to implement interoperable electronic health records systems that
2591 satisfy standards established by the institute; and (2) physicians, hospitals and community health
2592 centers that are eligible for incentive payments but lack access, as reasonably determined by the
2593 director of the institute, to resources needed to support their meeting meaningful use standards as
2594 determined in accordance with the federal Health Information Technology for Economic and
2595 Clinical Health Act. In the case of hospitals eligible for funding from the Distressed Hospital
2596 Trust Fund, established under section 2GGGG of chapter 29 and administered by the health
2597 policy commission under section 2 of chapter 6D, the institute shall first determine if there is
2598 available funding within the Distressed Hospital Fund to support their meeting meaningful use
2599 standards as determined in accordance with the federal Health Information Technology for
2600 Economic and Clinical Health Act. Individual or institutional providers under clause (1) may
2601 include, but shall not be limited to, mental health facilities and community-based behavioral
2602 health, substance use disorder and mental health care providers, chronic care and rehabilitation
2603 hospitals, skilled nursing facilities, visiting nursing associations, home health providers,
2604 registered nurses, licensed practical nurses, physicians, physician assistants, chiropractors,
2605 dentists, occupational therapists, physical therapists, optometrists, pharmacists, podiatrists,
2606 psychologists and social workers. In making the determinations regarding available resources as
2607 described in clauses (1) and (2), the director of the institute shall consider:

2608 (A) the demonstrated need for investment, taking into account all resources
2609 available to the particular provider including the relationship or affiliation of the particular

2610 provider to a health care delivery system and the capacity of such system to provide financial
2611 support for the provider's meeting the standards established by the institute or meaningful use
2612 standards;

2613 (B) the anticipated return on investment, as measured by improved health care
2614 coordination, reduction in health care costs, reduction in unwarranted treatment variation and
2615 elimination of wasteful paper-based processes;

2616 (C) the amount of financial or in-kind support the particular provider will commit
2617 to supplementing or supporting any investment by the corporation;

2618 (D) whether there is a reasonable likelihood that the provider's use of such
2619 amounts will achieve the long term benefits expected from implementing an interoperable
2620 electronic health records system;

2621 (E) whether the investment will support innovative health care delivery and
2622 payment models as identified by the health policy commission;

2623 (F) whether the investment will support efforts to integrate mental health,
2624 behavioral and substance use disorder services with overall medical care;

2625 (G) the extent to which the investment will support efforts to meet the health care
2626 cost growth benchmark established by the health policy commission;

2627 (H) whether the provider serves a high proportion of public payer clients; and

2628 (I) any other factors that the director determines are appropriate.

2629 The institute shall consult with the office of Medicaid to maximize all opportunities to
2630 qualify any expenditures for federal financial participation. Applications for funding shall be in
2631 the form and manner determined by the institute director, and shall include the information and
2632 assurances required by the institute director. The institute director may consider, as a condition
2633 for awarding grants, the grantee's financial participation and any other factors it deems relevant.

2634 All grants shall be recommended by the institute director and subsequently approved by
2635 the executive director. The institute director shall work with implementation organizations to
2636 oversee the grant-making process as it relates to an implementing organization's responsibilities
2637 under its contract with the corporation. Each recipient of monies from this program shall: (i)
2638 capture and report certain quality improvement data, as determined by the institute in
2639 consultation with the department of public health and the center for health information and
2640 analysis; (ii) fully implement an electronic health record system, including all clinical features,
2641 with the maximum feasible level of interoperability, not later than the second year of the grant;
2642 and (iii) make use of the system's full range of features. In the event that any recipient of grant
2643 monies from this program does not achieve installation of a fully functioning electronic health
2644 record system or does not achieve the appropriate level of interoperability within the 2 year grant
2645 period, such recipient shall be required to repay to the corporation all or some portion, as
2646 determined by the corporation, of the grant funds previously provided to such recipient under
2647 this section.

2648 (I) The institute shall establish a pilot partnership with community colleges or vocational
2649 technology schools in the commonwealth to support health information technology curriculum
2650 development and workforce development. Funding for the program shall be from the Health
2651 Care WorkForce Transformation Trust Fund established under section 2FFFF of chapter 29.

2652 (J) The institute shall encourage and promote the implementation by hospitals, clinics,
2653 and health care networks of evidence-based best practice clinical decision support tools for the
2654 ordering provider of advanced diagnostic imaging services by January 1, 2017. Advanced
2655 diagnostic imaging services shall include, but is not limited to, computerized tomography,
2656 magnetic resonance imaging, magnetic resonance angiography, positon emission tomography,
2657 nuclear medicine, and such other imaging services. The institute shall develop clinical decision
2658 support guidelines and protocols that may be incorporated into the provider order entry systems
2659 of hospitals and the electronic health records of providers, to the maximum extent possible for
2660 certified EHR technology. The use of such decision support tools shall meet the privacy and
2661 security standards promulgated pursuant to the federal Health Insurance Portability and
2662 Accountability Act of 1996 (Public Law 104-119).

2663 In addition, the institute shall advance the dissemination of innovative technologies, including,
2664 but not limited to, those technologies that would allow diagnostic imaging exams to be
2665 seamlessly processed and transferred electronically through means that may include, but shall
2666 not be limited to, cloud-based technologies.

2667 (K) The institute shall file an annual report, not later than January 30, with the joint
2668 committee on health care financing, the joint committee on economic development and emerging
2669 technologies and the house and senate committees on ways and means concerning the activities
2670 of the institute in general and, in particular, describing the progress to date in implementing
2671 interoperableprovider electronic health records systems and recommending such further
2672 legislative action as it considers appropriate.

2673 Section 6E. (a) There shall be established and set up on the books of the corporation a
2674 separate fund to be known as the e-Health Institute Fund, referred to in this section as the fund.
2675 There shall be credited to the fund revenue from appropriations or other monies authorized by
2676 the general court and specifically designated to be credited to the fund, including but not limited
2677 to any investment income earned on the fund's assets and all other sources. The corporation
2678 shall hold the fund in an account or accounts separate from other funds, including other funds
2679 established under this chapter. Amounts credited to the fund shall be available for reasonable
2680 expenditure by the corporation, without further appropriation, for any and all activities consistent
2681 with this section and supportive of the purposes specified in section 6D, including but not limited
2682 to, in the form of grants, contracts, loans and such other vehicles as the corporation may
2683 determine are appropriate. Amounts credited to the fund shall be expended or applied only with
2684 the approval of the executive director of the corporation upon consultation with the health
2685 information technology council established under section 2 of chapter 118I of the General Laws.
2686 Amounts credited to the fund shall not be applied to the commonwealth's match for federal
2687 funds for which a state match is required unless the federal funds to be matched are allocated to
2688 the corporation for use to further the purposes set out in this section, as reasonably determined by
2689 the executive director of the corporation; provided, however, that there are no other sources of
2690 funds available to meet federal matching requirements in order to secure such federal funds, as
2691 reasonably determined by the executive director of the corporation. Revenues deposited in the
2692 fund that are unexpended at the end of the fiscal year shall not revert to the General Fund and
2693 shall be available for expenditure in the following fiscal year.

2694 SECTION 39. Said chapter 40J is hereby further amended by inserting after section 6E
2695 the following section:-

2696 Section 6E ½. (a) There shall be established and set up on the books of the corporation
2697 the Massachusetts Health Information Technology Revolving Loan Fund, hereinafter referred to
2698 as the fund, the proceeds of which shall be used to provide zero-interest loans to health care
2699 providers and community-based behavioral health organizations to implement health information
2700 technology. There shall be credited to the fund any appropriations or other monies authorized by
2701 the general court and specifically designated to be credited to the fund; proceeds of any bonds or
2702 notes of the commonwealth issued for the purpose; any federal grants or loans; any private gifts,
2703 grants or donations made available; and any income derived from the investment of amounts
2704 credited to the fund. The director of the institute shall pursue and maximize all opportunities to
2705 qualify for federal financial participation. The institute shall seek, to the greatest extent possible,
2706 private gifts, grants and donations to the fund. The fund shall be held in an account or accounts
2707 separate from other funds. The fund shall be administered by the institute without further
2708 appropriation. Amounts credited to the fund shall be available for reasonable expenditure by the
2709 corporation, for purposes as the corporation determines are necessary to support the
2710 dissemination and development of health information technology in the commonwealth,
2711 including, but not limited to, the loan program established in this section. Any funds remaining
2712 in the fund at the end of a fiscal year shall be carried forward into the following fiscal year and
2713 shall remain available for expenditure without further appropriation.

2714 (b) The institute shall make available zero interest loan funding from the Massachusetts
2715 Health Information Technology Revolving Loan Fund to health care providers to assist with the
2716 development and implementation of an interoperable health information technology system that
2717 meets all federal and state requirements. The institute shall make the loans available through
2718 banks approved to do business in the commonwealth by the division of banks. The institute shall

2719 enter into agreements with the lenders to make loans. The institute, in consultation with the state
2720 treasurer, shall develop a lender partnership program and lender agreement that requires, at a
2721 minimum, (1) that a bank must be adequately capitalized, consistent with the requirements of
2722 209 CMR 47.00 et seq. and as defined under the prompt corrective action provisions of the
2723 Federal Deposit Insurance Act, 12 U.S.C. section 1831(o), and the Federal Deposit Insurance
2724 Corporation's Capital Adequacy Regulations, 12 CFR section 325.103; (2) the institute shall
2725 specify lending standards, including without limitation, those for determining eligibility,
2726 including the eligibility standards set forth in this subsection, size and number of loans, and (3)
2727 that all loans made under the program must be zero interest loans; provided, however, that the
2728 program may provide for reasonable application and administrative fees to be paid to lending
2729 banks under the program. A reasonable amount of administrative costs may be expended
2730 annually from the fund for the administration of the program. Any application or other fees
2731 imposed and collected under this program shall be deposited in the Massachusetts Health
2732 Information Technology Revolving Loan Fund for the duration of the loan program. The institute
2733 may make adjustments necessary to loan applications to account for reimbursements received
2734 under any other state or federal programs. To be eligible for a loan under this section, a health
2735 care provider, at a minimum, shall provide the participating lending institution with the
2736 following information: (A) the amount of the loan requested and a description of the purpose or
2737 project for which the loan proceeds will be used; (B) a price quote from a vendor; (C) a
2738 description of the health care provider or entities and other groups participating in the project;
2739 (D) evidence of financial condition and ability to repay the loan; and (E) a description of how the
2740 loan funds will be used to bring the health care provider into compliance with federal and state
2741 requirements. Loans shall be repaid over a 5-year term according to a schedule to be established

2742 through institute regulations. The attorney general shall enforce collection of any loans in
2743 default.

2744 The institute shall promulgate regulations necessary for the operation of this program.

2745 SECTION 40. Sections 6F and 6G of said chapter 40J are hereby repealed.

2746 SECTION 41. Chapter 62 of the General Laws is hereby amended by inserting after
2747 section 6M the following section:-

2748 Section 6N. (a) The purpose of this section shall be to provide incentives for business to
2749 recognize the benefits of wellness programs. Wellness programs implemented by business have
2750 resulted in both savings to their premiums as well as overall savings to the cost of health care.

2751 The goal of this tax credit is to provide smaller businesses with an expanded opportunity to
2752 implement these programs.

2753 (b) There is hereby established a Massachusetts wellness program tax credit. The total of all tax
2754 credits available to a taxpayer pursuant to this section or section 38FF of chapter 63 shall not
2755 exceed \$10,000 in any 1 tax year. A business that implements a wellness program shall be
2756 allowed a credit, to be computed as hereinafter provided, against taxes owed to the
2757 commonwealth under chapter 62 or chapter 63 or other applicable law. For the purposes of this
2758 section, "businesses" shall include professions, sole proprietorships, trades, businesses, or
2759 partnerships.

2760 (c) The credit allowed under this chapter shall be equal to 25 per cent of the costs
2761 associated with implementing a program certified under section 206A of chapter 111, with a
2762 maximum credit of \$10,000 per business in any 1 fiscal year. The department of public health

2763 shall determine the criteria for eligibility for the credit, the criteria to be set forth in regulations
2764 promulgated under this section and section 206A of chapter 111. The regulations shall require
2765 proof of using a wellness program qualified under section 206A of chapter 111. The department
2766 shall issue a certification to the taxpayer after the taxpayer submits documentation as required by
2767 the department. Such certification shall be acceptable as proof that the expenditures related to
2768 the implementation of a wellness program for the purposes of the credit allowed under this
2769 section.

2770 (d) Wellness program tax credits allowed to a business under this section shall be allowed
2771 for the taxable year in which the program is implemented; provided, however, that a tax credit
2772 allowed under this section shall not reduce the tax owed below zero. A taxpayer allowed a credit
2773 under this section for a taxable year may carry over and apply against such taxpayer's tax
2774 liability in any of the succeeding 5 taxable years, the portion, as reduced from year to year, of
2775 those credits which exceed the tax for the taxable year.

2776 SECTION 41A. Section 6N of chapter 62 of the General Laws is hereby repealed.

2777 SECTION 43. Section 21 of said chapter 62C, as so appearing, is hereby amended by
2778 striking out, in lines 141 and 142, the words "division of health care finance and policy" and
2779 inserting in place thereof the following words:- executive office of health and human services.

2780 SECTION 44. Section 21 of said chapter 62C, as so appearing, is hereby further amended
2781 by striking out, in line 143, the word "118G" and inserting in place thereof the following word:-
2782 118E.

2783 SECTION 45. Section 21 of said chapter 62C, as so appearing, is hereby further amended
2784 by striking out, in line 145, the words “division of health care finance and policy” and inserting
2785 in place thereof the following words:- executive office of health and human services.

2786 SECTION 46. Said section 21 of said chapter 62C, as so appearing, is hereby further
2787 amended by striking out, in lines 148 and 149, the words “section 39 of chapter 118G” and
2788 inserting in place thereof the following words:- section 69 of chapter 118E.

2789 SECTION 47. Section 1 of chapter 62D of the General Laws, as appearing in the 2010
2790 Official Edition, is hereby amended by striking out, in lines 8 and 9, the words “the division of
2791 health care finance and policy in the exercise of its duty to administer the uncompensated care
2792 pool pursuant to chapter 118G” and inserting in place thereof the following words:- the executive
2793 office of health and human services in the exercise of its duty to administer the Health Safety Net
2794 Trust Fund under chapter 118E.

2795 SECTION 48. Said section 1 of said chapter 62D, is hereby amended by striking out in
2796 lines 30 to 35, inclusive, as so appearing, the words “division of health care finance and policy
2797 on behalf of the uncompensated care pool by a person or a guarantor of a person who received
2798 free care services paid for in whole or in part by the uncompensated care pool or on whose behalf
2799 the uncompensated care pool paid for emergency bad debt, pursuant to subsection (m) of section
2800 18 of chapter 118G” and inserting in place thereof the following words:- executive office of
2801 health and human services on behalf of the Health Safety Net Trust Fund by a person or a
2802 guarantor of a person who received free care services paid for in whole or in part by the Health
2803 Safety Net Trust Fund or on whose behalf said fund paid for emergency bad debt.

2804 SECTION 49. Said section 1 of said chapter 62D is hereby amended by striking out, in
2805 line 55, as so appearing, the words “section 39 of chapter 118G” and inserting in place thereof
2806 the following words:- section 69 of chapter 118E.

2807 SECTION 50. Section 8 of said chapter 62D, as so appearing in the 2010 Official
2808 Edition, is hereby amended by striking out the second paragraph.

2809 SECTION 51. Section 10 of said chapter 62D, as so appearing, is hereby amended by
2810 striking out, in lines 8 and 9, the words “the division of medical assistance, the corporation, the
2811 office of the state comptroller, and the division of health care finance and policy” and inserting
2812 in place thereof the following words:- the office of medicaid, the corporation, the office of the
2813 state comptroller and the executive office of health and human services.

2814 SECTION 52. Section 13 of said chapter 62D, as so appearing, is hereby amended by
2815 striking out, in lines 11 and 12, the words “section 39 of chapter 118G” and inserting in place
2816 thereof the following words:- section 69 of chapter 118E.

2817 SECTION 53. Section 3 of chapter 62E of the General Laws, as so appearing, is hereby
2818 amended by striking out, in lines 7 and 8, the words “division of health care finance and policy”
2819 and inserting in place thereof the following words:- executive office of health and human
2820 services.

2821 SECTION 54. Section 12 of said chapter 62E, as so appearing, is hereby amended by
2822 striking out, in lines 19 and 20, the words “division of health care finance and policy” and
2823 inserting in place thereof the following words:- executive office of health and human services.

2824 SECTION 55. Said section 12 of said chapter 62E, as so appearing, is hereby further
2825 amended by striking out, in lines 21 and 22, the words “sections 34 to 39, inclusive, of chapter
2826 118G and sections 6B, 6C and 18B of chapter 118G” and inserting in place thereof the following
2827 words:- sections 64 to 69, inclusive, of chapter 118E and sections 17 and 18 of chapter 176Q.

2828 SECTION 56. Chapter 63 of the General Laws is hereby amended by inserting after
2829 section 38EE the following section:-

2830 Section 38FF. (a) The purpose of this section shall be to provide incentives for business
2831 to recognize the benefits of wellness programs. Wellness programs implemented by business
2832 have resulted in both savings to their premiums as well as overall savings to the cost of health
2833 care. The goal of this tax credit is to provide smaller businesses with an expanded opportunity to
2834 implement these programs.

2835 (b) There is hereby established a Massachusetts wellness program tax credit. The total of
2836 all tax credits available to a taxpayer pursuant to this section or section 6N of chapter 62 shall not
2837 exceed \$10,000 in any 1 tax year. A business that implements a wellness program shall be
2838 allowed a credit, to be computed as hereinafter provided, against taxes owed to the
2839 commonwealth under chapter 62 or chapter 63 or other applicable law. For the purposes of this
2840 section, “businesses” shall include professions, sole proprietorships, trades, businesses or
2841 partnerships.

2842 (c) The credit allowed under this chapter shall be equal to 25 per cent of the costs
2843 associated with implementing the program, with a maximum credit of \$10,000 per business in
2844 any 1 fiscal year. The department of public health shall determine the criteria for eligibility for
2845 the credit, such criteria to be set forth in regulations promulgated under this section. The

2846 regulations shall require proof of using a wellness program qualified under section 206A of
2847 chapter 111. The department shall issue a certification to the taxpayer after the taxpayer submits
2848 documentation as required by the department. The certification shall be acceptable as proof that
2849 the expenditures related to the implementation of a wellness program for the purposes of the
2850 credit allowed under this section.

2851 (d) The credit allowed in this chapter for any taxable year shall not reduce the excise to
2852 less than the amount due under subsection (b) of section 39, section 67 or any other applicable
2853 section.

2854 (e) Wellness program tax credits allowed to a business under this section shall be allowed
2855 for the taxable year in which the program is implemented. A taxpayer allowed a credit under this
2856 section for a taxable year may carry over and apply against the taxpayer's tax liability in any of
2857 the succeeding 5 taxable years, the portion, as reduced from year to year, of those credits which
2858 exceed the tax for the taxable year.

2859 SECTION 56A. Section 38FF of chapter 63 of the General Laws is hereby repealed.

2860 SECTION 57. Section 17A of chapter 66 of the General Laws, as appearing in the 2010
2861 Official Edition, is hereby amended by striking out, in line 11, the word "118G" and inserting in
2862 place thereof the following word:- 118E.

2863 SECTION 58. Section 3 of chapter 71B of the General Laws, as so appearing, is hereby
2864 amended by striking out, in line 177, the words "2A of chapter 118G" and inserting in place
2865 thereof the following words:- 13C of chapter 118E.

2866 SECTION 59. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby
2867 amended by inserting after the definition of “Nuclear reactor” the following definition:-

2868 “Primary care provider”, a health care professional qualified to provide general medical
2869 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
2870 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
2871 maintains continuity of care within the scope of practice.

2872 SECTION 60. Said chapter 111 is hereby amended by inserting after section 2F the
2873 following 2 sections:-

2874 Section 2G. (a) There shall be established and set upon the books of the commonwealth a
2875 separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without
2876 further appropriation, by the department of public health. The fund shall consist of revenues
2877 collected by the commonwealth including: (1) any revenue from appropriations or other monies
2878 authorized by the general court and specifically designated to be credited to the fund; (2) any
2879 fines and penalties allocated to the fund under the General Laws; (3) any funds from public and
2880 private sources such as gifts, grants and donations to further community-based prevention
2881 activities; (4) any interest earned on such revenues; and (5) any funds provided from other
2882 sources.

2883 The commissioner of public health, as trustee, shall administer the fund. The
2884 commissioner, in consultation with the Prevention and Wellness Advisory Board established
2885 under section 2H, shall make expenditures from the fund consistent with subsections (d) and (e);
2886 provided, that not more than 15 per cent of the amounts held in the fund in any 1 year shall be

2887 used by the department for the combined cost of program administration, technical assistance to
2888 grantees or program evaluation.

2889 (b) Revenues deposited in the fund that are unexpended at the end of the fiscal year shall
2890 not revert to the General Fund and shall be available for expenditure in the following fiscal year.

2891 (c) All expenditures from the Prevention and Wellness Trust Fund shall support the
2892 state's efforts to meet the health care cost growth benchmark established in section 9 of chapter
2893 6D and any activities funded by the Healthcare Payment Reform Fund and 1 or more of the
2894 following purposes: (1) reduce rates of the most prevalent and preventable health conditions,
2895 including substance abuse; (2) increase healthy behaviors; (3) increase the adoption of
2896 workplace-based wellness or health management programs that result in positive returns on
2897 investment for employees and employers; (4) address health disparities; or (5) develop a stronger
2898 evidence-base of effective prevention programming.

2899 (d) The commissioner shall annually award not less than 75 per cent of the Prevention
2900 and Wellness Trust Fund through a competitive grant process to municipalities, community-
2901 based organizations, health care providers, regional-planning agencies, and health plans that
2902 apply for the implementation, evaluation and dissemination of evidence-based community
2903 preventive health activities. To be eligible to receive a grant under this subsection, a recipient
2904 shall be: (1) a municipality or group of municipalities working in collaboration; (2) a
2905 community-based organization working in collaboration with 1 or more municipalities; (3) a
2906 health care provider or a health plan working in collaboration with 1 or more municipalities and
2907 a community-based organization; or (4) a regional planning agency. Expenditures from the fund
2908 for such purposes shall supplement and not replace existing local, state, private or federal public

2909 health-related funding; or a community-based organization or group of community-based
2910 organizations working in collaboration.

2911 (e) A grant proposal submitted under subsection (d) shall include, but not be limited to:
2912 (1) a plan that defines specific goals for the reduction in preventable health conditions and health
2913 care costs over a multi-year period; (2) the evidence-based programs the applicant shall use to
2914 meet the goals; (3) a budget necessary to implement the plan, including a detailed description of
2915 any funding or in-kind contributions the applicant or applicants will be providing in support of
2916 the proposal; (4) any other private funding or private sector participation the applicant anticipates
2917 in support of the proposal; (5) a commitment to include women, racial and ethnic minorities and
2918 low income individuals; and (6) the anticipated number of individuals that would be affected by
2919 implementation of the plan.

2920 Priority may be given to proposals in a geographic region of the state with a higher than
2921 average prevalence of preventable health conditions, as determined by the commissioner of
2922 public health, in consultation with the Prevention and Wellness Advisory Board. If no proposals
2923 were offered in areas of the state with particular need, the department shall ask for a specific
2924 request for proposal for that specific region. If the commissioner determines that no suitable
2925 proposals have been received, such that the specific needs remain unmet, the department may
2926 work directly with municipalities or community-based organizations to develop grant proposals.

2927 The department of public health shall, in consultation with the Prevention and Wellness
2928 Advisory Board, develop guidelines for an annual review of the progress being made by each
2929 grantee. Each grantee shall participate in any evaluation or accountability process implemented
2930 or authorized by the department.

2931 (f) The commissioner of public health may annually expend not more than 10 per cent of
2932 the Prevention and Wellness Trust Fund to support the increased adoption of workplace-based
2933 wellness or health management programming. The department of public health shall expend
2934 such funds for activities including, but not limited to: (1) developing and distributing
2935 informational tool-kits for employers, including a model wellness guide developed by the
2936 department; (2) providing technical assistance to employers implementing wellness programs;
2937 (3) hosting informational forums for employers; (4) promoting awareness of wellness tax credits
2938 provided through the state and federal government, including the wellness subsidy provided by
2939 the commonwealth health connector authority; (5) public information campaigns that quantify
2940 the importance of healthy lifestyles, disease prevention, care management and health promotion
2941 programs; and (6) providing stipends or grants to employers for the implementation and
2942 administration of workplace wellness programs in an amount up to 50 per cent of the costs
2943 associated with implementing the plan, subject to a cap as established by the commissioner based
2944 on available funds; provided, however, that any grants offered in connection with a workplace
2945 wellness program eligible for a tax credit under section 6N of chapter 62 and section 38FF of
2946 chapter 63 shall not, in combination with such tax credit, exceed 50 per cent of the costs
2947 associated with implementing the plan.

2948 The department of public health shall develop guidelines to annually review progress
2949 toward increasing the adoption of workplace-based wellness or health management
2950 programming.

2951 (g) The department of public health shall, annually on or before January 31, report on
2952 expenditures from the Prevention and Wellness Trust Fund. The report shall include, but not be
2953 limited to: (1) the revenue credited to the fund; (2) the amount of fund expenditures attributable

2954 to the administrative costs of the department of public health; (3) an itemized list of the funds
2955 expended through the competitive grant process and a description of the grantee activities; (4)
2956 the results of the evaluation of the effectiveness of the activities funded through grants; and (5)
2957 an itemized list of expenditures used to support workplace-based wellness or health management
2958 programs. The report shall be provided to the chairpersons of the house and senate committees
2959 on ways and means and the joint committee on public health and shall be posted on the
2960 department of public health's website.

2961 (h) The department of public health shall, under the advice and guidance of the
2962 Prevention and Wellness Advisory Board, annually report on its strategy for administration and
2963 allocation of the fund, including relevant evaluation criteria. The report shall set forth the
2964 rationale for such strategy, including, but not limited to: (1) a list of the most prevalent
2965 preventable health conditions in the commonwealth, including health disparities experienced by
2966 populations based on race, ethnicity, gender, disability status, sexual orientation or socio-
2967 economic status; (2) a list of the most costly preventable health conditions in the commonwealth;
2968 (3) a list of evidence-based or promising community-based programs related to the conditions
2969 identified in clauses (1) and (2); and (4) a list of evidence-based workplace wellness programs or
2970 health management programs related to the conditions in clauses (1) and (2). The report shall
2971 recommend specific areas of focus for allocation of funds. If appropriate, the report shall
2972 reference goals and best practices established by the National Prevention and Public Health
2973 Promotion Council and the Centers for Disease Control and Prevention, including, but not
2974 limited to the national prevention strategy, the healthy people report and the community
2975 prevention guide.

2976 (i) The department of public health shall promulgate regulations necessary to carry out
2977 this section.

2978 Section 2H. There shall be a Prevention and Wellness Advisory Board to make
2979 recommendations to the commissioner concerning the administration and allocation of the
2980 Prevention and Wellness Trust Fund established in section 2G, establish evaluation criteria and
2981 perform any other functions specifically granted to it by law.

2982 The board shall consist of: the commissioner of public health or a designee, who shall
2983 serve as chairperson; the executive director of the institute of health care finance and policy
2984 established in chapter 12C or a designee; the secretary of health and human services or a
2985 designee; and 14 persons to be appointed by the governor, 1 of whom shall be a person with
2986 expertise in the field of public health economics; 1 of whom shall be a person with expertise in
2987 public health research; 1 of whom shall be a person with expertise in the field of health equity; 1
2988 of whom shall be a person from a local board of health for a city or town with a population
2989 greater than 50,000; 1 of whom shall be a person of a board of health for a city or town with a
2990 population of fewer than 50,000; 2 of whom shall be representatives of health insurance carriers;
2991 1 of whom shall be a person from a consumer health organization; 1 of whom shall be a person
2992 from a hospital association; 1 of whom shall be a person from a statewide public health
2993 organization; 1 of whom shall be a representative of the interest of businesses; 1 of whom shall
2994 administer an employee assistance program; 1 of whom shall be a public health nurse or a school
2995 nurse; and 1 of whom shall be a person from an association representing community health
2996 workers.

2997 SECTION 61. Section 4H of chapter 111 of the General Laws, as appearing in the 2010
2998 Official Edition, is hereby amended by striking out, in line 20, the words “division of health care
2999 finance and policy” and inserting in place thereof the following words:- executive office of
3000 health and human services, or a governmental unit designated by the executive office.

3001 SECTION 62. Section 25B of said chapter 111, as so appearing, is hereby amended by
3002 striking out, in lines 23 and 24, the words “1 of chapter 118G” and inserting in place thereof the
3003 following words:- 8A of chapter 118E.

3004 SECTION 63. Said section 25B of said chapter 111, as so appearing, is hereby further
3005 amended by inserting after the word “has”, in line 35, the following word:- been.

3006 SECTION 64. Said section 25B of said chapter 111, as so appearing, is hereby further
3007 amended by striking out, in lines 47 and 48, the words “, institution for the care of unwed
3008 mothers”.

3009 SECTION 65. Said section 25B of said chapter 111, as so appearing, is hereby further
3010 amended by striking out, in line 49, the words “, which is an infirmary maintained in a town”.

3011 SECTION 66. Said section 25B of said chapter 111, as so appearing, is hereby further
3012 amended by striking out, in line 54, the words “mentally ill or retarded” and inserting in place
3013 thereof the following words:- developmentally disabled or mentally ill.

3014 SECTION 67. Said section 25B of said chapter 111, as so appearing, is hereby further
3015 amended by inserting after the word “basis”, in line 85, the following words:- whether provided
3016 in a free standing ambulatory surgical center licensed as a clinic pursuant to section 51 or by a
3017 hospital.

3018 SECTION 68. Said section 25B of said chapter 111, as so appearing, is hereby further
3019 amended by striking out the definition “Innovative service” and inserting in place thereof the
3020 following definition:-

3021 “Innovative service”, a service or procedure, which for reasons of quality, access, or cost
3022 is determined to be innovative by the department.

3023 SECTION 69. Said section 25B of said chapter 111, as so appearing, is hereby further
3024 amended by striking out the definition “New technology” and inserting in place thereof the
3025 following definition:-

3026 “New technology”, equipment such as magnetic resonance imagers and linear
3027 accelerators, as defined by the department, or a service, as defined by the department, which for
3028 reasons of quality, access or cost is determined to be new technology by the department.

3029 SECTION 70. Said section 25B of said chapter 111, as so appearing, is hereby further
3030 amended by striking out, in lines 120 to121, the words “A new technology or innovate” and
3031 inserting in place thereof the following words:- a new technology or innovative.

3032 SECTION 71. Said chapter 111 is hereby amended by striking out section 25C and
3033 inserting in place thereof the following section:-

3034 Section 25C. (a) Notwithstanding any general or special law to the contrary, except as
3035 provided in section 25 C½, a person or agency of the commonwealth or any political subdivision
3036 thereof shall not make substantial capital expenditures for construction of a health care facility or
3037 substantially change the service of the facility unless there is a determination by the department
3038 that there is need for the construction or change. A determination of need shall not be required

3039 for any substantial capital expenditure for construction or any substantial change in service
3040 which shall be related solely to the conduct of research in the basic biomedical or applied
3041 medical research areas and shall at no time result in any increase in the clinical bed capacity or
3042 outpatient load capacity of a health care facility and shall not be included within or cause an
3043 increase in the gross patient service revenue of a facility for health care services, supplies and
3044 accommodations, as such revenue shall be defined under section 31 of chapter 6A. Any person
3045 undertaking an expenditure related solely to that research which shall exceed or may reasonably
3046 be regarded as likely to exceed \$150,000 or any change in service solely related to the research,
3047 shall give written notice of the expenditure or change in service to the department the center for
3048 health information and analysis and the health policy commission, and the health policy
3049 commission at least 60 days before undertaking the expenditure or change in service. The notice
3050 shall state that the expenditure or change shall be related solely to the conduct of research in the
3051 basic biomedical or applied medical research areas and shall not be included within or result in
3052 any increase in the clinical bed capacity or outpatient load capacity of a facility and shall not
3053 cause an increase in the gross patient service revenue, as defined in under said section 31 of said
3054 chapter 6A, of a facility for health care services, supplies and accommodations; provided,
3055 however, that if it is subsequently determined that there was a violation of this section, the
3056 applicant may be punished by a fine of not more than 3 times the amount of the expenditure or
3057 value of the change of service.

3058 (b) Notwithstanding subsection (a), a determination of need shall be required for any such
3059 expenditure or change if the notice required by this section is not filed in accordance with the
3060 requirements of this section or if the department finds, after receipt of the notice, that the
3061 expenditure or change will not be related solely to research in the basic biomedical or applied

3062 medical research areas, will result in an increase in the clinical bed capacity or outpatient load
3063 capacity of a facility or will be included within or cause an increase in the gross patient service
3064 revenues of a facility. A research exemption granted under this section shall not be deemed to be
3065 evidence of need in any determination of need proceeding.

3066 (c) A person or agency of the commonwealth or any political subdivision thereof shall
3067 not provide an innovative service or use a new technology in any location other than in a health
3068 care facility, unless the person or agency first is issued a determination of need for the innovative
3069 service or new technology by the department.

3070 (d) A person or agency of the commonwealth or any political subdivision thereof shall
3071 not acquire for location in other than a health care facility a unit of medical, diagnostic, or
3072 therapeutic equipment, other than equipment used to provide an innovative service or which is a
3073 new technology, as such terms are defined in section 25B, with a fair market value in excess of
3074 \$250,000, to be adjusted in a similar fashion as section 25B1/2, unless the person or agency
3075 notifies the department of the person's or agency's intent to acquire the equipment and of the use
3076 that will be made of the equipment; provided, however, that maintenance or replacement of
3077 existing equipment defined as new technology shall not require a review. The notice shall be
3078 made in writing and shall be received by the department at least 30 days before contractual
3079 arrangements are entered into to acquire the equipment with respect to which notice is given. A
3080 determination by the department of need shall be required for any the acquisition (1) if the notice
3081 required by this paragraph is not filed in accordance with the requirements of this paragraph, and
3082 (2) if the requirements for exemption under subsection (a) of section 25C^{1/2} are not met;
3083 provided, however, that in no event shall any person who acquires a unit of new technology for
3084 location other than in a health care facility refer or influence any referrals of patients to the

3085 equipment, unless the person is a physician directly providing services with that equipment;
3086 provided, however, that for the purposes of this section, a public advertisement shall not be
3087 deemed a referral or an influence of referrals; and provided, further, that any person who has an
3088 ownership interest in the equipment, whether direct or indirect, shall disclose the interest to
3089 patients utilizing said equipment in a conspicuous manner.

3090 (e) Each person or agency operating a unit of equipment described in this section shall
3091 submit annually to the department information and data in connection with utilization and
3092 volume rates of said equipment on a form or forms prescribed by the department.

3093 (f) Except as provided in section 25 C½, a person or agency of the commonwealth or any
3094 political subdivision thereof shall not acquire an existing health care facility unless the person or
3095 agency notifies the department of the person's or agency's intent to acquire the facility and of
3096 the services to be offered in the facility and its bed capacity. The notice shall be made in writing
3097 and shall be received by the department at least 30 days before contractual arrangements are
3098 entered into to acquire the facility with respect to which the notice is given. A determination of
3099 need shall be required for any such acquisition if the notice required by this subsection is not
3100 filed in accordance with the requirements of this subsection or if the department finds, within 30
3101 days after receipt of notice under this subsection, that the services or bed capacity of the facility
3102 will be changed in being acquired.

3103 (g) The department, in making any determination of need, shall be guided by the state
3104 health plan, shall encourage appropriate allocation of private and public health care resources
3105 and the development of alternative or substitute methods of delivering health care services so
3106 that adequate health care services will be made reasonably available to every person within the

3107 commonwealth at the lowest reasonable aggregate cost, shall take into account any comments
3108 from the center for health information and analysis, the health policy commission, and any other
3109 state agency or entity, and may impose reasonable terms and conditions as the department
3110 determines are necessary to achieve the purposes and intent of this section. The department may
3111 also recognize the special needs and circumstances of projects that: (1) are essential to the
3112 conduct of research in basic biomedical or health care delivery areas or to the training of health
3113 care personnel; (2) are unlikely to result in any increase in the clinical bed capacity or outpatient
3114 load capacity of the facility; and (3) are unlikely to cause an increase in the total patient care
3115 charges of the facility to the public for health care services, supplies, and accommodations, as
3116 such charges shall be defined from time to time in accordance with section 5 of chapter 409 of
3117 the acts of 1976.

3118 (h) Applications for such determination shall be filed with the department, together with
3119 other forms and information as shall be prescribed by, or acceptable to, the department. A
3120 duplicate copy of any application together with supporting documentation for such application,
3121 shall be a public record and kept on file in the department. The department may require a public
3122 hearing on any application at its discretion or at the request of the attorney general. The attorney
3123 general may intervene in any hearing under this section. A reasonable fee, established by the
3124 department, shall be paid upon the filing of such application; provided, however, that in no event
3125 shall such fee exceed 0.2 per cent of the capital expenditures, if any, proposed by the applicant.
3126 The department may also require the applicant to provide an independent cost-analysis,
3127 conducted at the expense of the applicant, to demonstrate that the application is consistent with
3128 the commonwealth's efforts to meet the health care cost-containment goals established by the
3129 commission.

3130 (i) Except in the case of an emergency situation determined by the department as
3131 requiring immediate action to prevent further damage to the public health or to a health care
3132 facility, the department shall not act upon an application for such determination unless: (1) the
3133 application has been on file with the department for at least 30 days; (2) the center for health care
3134 information and analysis, the health policy commission, the state and appropriate regional
3135 comprehensive health planning agencies and, in the case of long-term care facilities only, the
3136 department of elder affairs, or in the case of any facility providing inpatient services for the
3137 mentally ill or developmentally disabled, the departments of mental health or developmental
3138 services, respectively, have been provided copies of such application and supporting documents
3139 and given reasonable opportunity to comment on such application; and (3) a public hearing has
3140 been held on such application when requested by the applicant, the state or appropriate regional
3141 comprehensive health planning agency or any 10 taxpayers of the commonwealth. If, in any
3142 filing period, an individual application is filed which would implicitly decide any other
3143 application filed during such period, the department shall not act only upon an individual.

3144 (j) The department shall so approve or disapprove in whole or in part each such
3145 application for a determination of need within 4 months after filing with the department;
3146 provided, however, that the department may, on 1 occasion only, delay the action for up to 2
3147 months after the applicant has provided information which the department reasonably has
3148 requested during the 8 month period. Applications remanded to the department by the health
3149 facilities appeals board under section 25E shall be acted upon by the department within the same
3150 time limits provided in this section for the department to approve or disapprove applications for a
3151 determination of need. If an application has not been acted upon by the department within such

3152 time limits, the applicant may, within a reasonable period of time, bring an action in the nature of
3153 mandamus in the superior court to require the department to act upon the application.

3154 (k) Determinations of need shall be based on the written record compiled by the
3155 department during its review of the application and on such criteria consistent with sections 25B
3156 to 25G, inclusive, as were in effect on the date of filing of the application. In compiling such
3157 record the department shall confine its requests for information from the applicant to matters
3158 which shall be within the normal capacity of the applicant to provide. In each case the action by
3159 the department on the application shall be in writing and shall set forth the reasons for such
3160 action; and every such action and the reasons for such action shall constitute a public record and
3161 be filed in the department.

3162 (l) The department shall stipulate the period during which a determination of need shall
3163 remain in effect, which in no event shall originally be longer than 3 years but which may be
3164 extended by the department for cause shown. Any such determination shall continue to be
3165 effective only upon the applicant: (1) making reasonable progress toward completing the
3166 construction or substantial change in services for which need was determined to exist; (2)
3167 complying with all other laws relating to the construction, licensure and operation of health care
3168 facilities; and (3) complying with such further terms and conditions as the department reasonably
3169 shall require.

3170 (m) The department shall notify the secretary of elder affairs forthwith of the pendency of
3171 any proceeding, of any public hearing and of any action to be taken under this section on any
3172 application submitted by or on behalf of any long-term care facility. In instances involving

3173 applications submitted on behalf of any facility providing inpatient services for the mentally ill
3174 or developmentally disabled, the department shall notify the appropriate commissioner.

3175 (n) A long-term care facility located in an under-bedded urban area shall not be replaced
3176 or the license for said facility transferred outside an under-bedded urban area. For the purposes
3177 of this subsection, an under-bedded urban area shall mean a city or town in which: (1) the per
3178 capita income is below the state average; (2) the percentage of the population below 100 per cent
3179 of the federal poverty level is above the state average; or (3) the percentage of the population
3180 below 200 per cent of the federal poverty level is above the state average.

3181 SECTION 72. Said chapter 111 is hereby further amended by striking out sections 25L,
3182 25M, and 25N and inserting in place thereof the following sections:-

3183 Section 25L. (a) There shall be in the department a health care workforce center to
3184 improve access to health and behavioral, substance use disorder and mental health care services.
3185 The center, in consultation with the health care workforce advisory council established by
3186 section 25M and the secretary of labor and workforce development, shall: (1) coordinate the
3187 department's health care workforce activities with other state agencies and public and private
3188 entities involved in health care workforce training, recruitment and retention, including with the
3189 activities of the Health Care Workforce Transformation Fund; (2) monitor trends in access to
3190 primary care providers, and nurse practitioners and physician assistants practicing as primary
3191 care providers, behavioral, substance use disorder and mental health providers, and other
3192 physician and nursing providers, through activities including (i) reviewing existing data and
3193 collection of new data as needed to assess the capacity of the health care and behavioral,
3194 substance use disorder and mental health care workforce to serve patients, including patients

3195 with disabilities whose disabilities may include but are not limited to intellectual and
3196 developmental disabilities, including patient access and regional disparities in access to
3197 physicians, nurses, physician assistants, and behavioral, substance use disorder and mental health
3198 care professionals and to examine physician, nursing and physician assistant, behavioral,
3199 substance use disorder and mental health professionals' satisfaction; (ii) reviewing existing laws,
3200 regulations, policies, contracting or reimbursement practices, and other factors that influence
3201 recruitment and retention of physicians, nurses, physician assistants, behavioral, substance use
3202 disorder and mental health professionals; (iii) projecting the ability of the workforce to meet the
3203 needs of patients over time; (iv) identifying strategies currently being employed to address
3204 workforce needs, shortages, recruitment and retention; (v) studying the capacity of public and
3205 private medical, nursing, physician assistant, behavioral, substance use disorder and mental
3206 health professional schools in the commonwealth to expand the supply of primary care
3207 physicians and nurse practitioners and physician assistants practicing as primary care providers
3208 and licensed behavioral, substance use disorder and mental health professionals; (3) establish
3209 criteria to identify underserved areas in the commonwealth for administering the loan repayment
3210 program established under section 25N and for determining statewide target areas for health care
3211 provider placement based on the level of access; and (4) address health care workforce shortages
3212 through the following activities, including: (i) coordinating state and federal loan repayment and
3213 incentive programs for health care providers; (ii) providing assistance and support to
3214 communities, physician groups, community health centers and community hospitals in
3215 developing cost-effective and comprehensive recruitment initiatives; (iii) maximizing all sources
3216 of public and private funds for recruitment initiatives; (iv) designing pilot programs and making
3217 regulatory and legislative proposals to address workforce needs, shortages, recruitment and

3218 retention; and (v) making short-term and long-term programmatic and policy recommendations
3219 to improve workforce performance, address identified workforce shortages and recruit and retain
3220 physicians, nurses, physician assistants and behavioral, substance use disorder and mental health
3221 professionals.

3222 (b) The center shall maintain ongoing communication and coordination with the health
3223 disparities council, established by section 16O of chapter 6A.

3224 (c) The center shall annually submit a report, not later than March 1, to the governor, the
3225 health disparities council, established by section 16O of chapter 6A; and the general court, by
3226 filing the same with the clerk of the house of representatives, the clerk of the senate, the joint
3227 committee on labor and workforce development, the joint committee on health care financing,
3228 and the joint committee on public health. The report shall include: (1) data on patient access and
3229 regional disparities in access to physicians, by specialty and sub-specialty, and nurses, physician
3230 assistants, behavioral, substance use disorder and mental health professionals; (2) data on factors
3231 influencing recruitment and retention of physicians, nurses, physician assistants, and behavioral,
3232 substance use disorder and mental health professionals; (3) short and long-term projections of
3233 physician, nurse, physician assistant and behavioral, substance use disorder and mental health
3234 professionals supply and demand; (4) strategies being employed by the council or other entities
3235 to address workforce needs, shortages, recruitment and retention; (5) recommendations for
3236 designing, implementing and improving programs or policies to address workforce needs,
3237 shortages, recruitment and retention; and (6) proposals for statutory or regulatory changes to
3238 address workforce needs, shortages, recruitment and retention.

3239 Section 25M. (a) There shall be a healthcare workforce advisory council within, but not
3240 subject to the control of, the health care provider workforce center established by section 25L.
3241 The council shall advise the center on the capacity of the healthcare workforce to provide timely,
3242 effective, culturally competent, quality physician, nursing, physician assistant, behavioral,
3243 substance use disorder and mental health services.

3244 (b) The council shall consist of: 19 members to be appointed by the governor: 1 of whom
3245 shall be a representative of the Massachusetts Extended Care Federation; 1 of whom shall be a
3246 physician with a primary care specialty designation who practices in a rural area; 1 of whom
3247 shall be a physician with a primary care specialty who practices in an urban area; 1 of whom
3248 shall be a physician with a medical subspecialty; 1 of whom shall be an advanced practice nurse,
3249 authorized under section 80B of said chapter 112, who practices in a rural area; 1 of whom shall
3250 be an advanced practice nurse, authorized under said section 80B of said chapter 112, who
3251 practices in an urban area; 1 of whom shall be a representative of the Massachusetts
3252 Organization of Nurse Executives; 1 of whom shall be a representative of the Massachusetts
3253 Academy of Family Physicians; 1 of whom shall be a representative of the Massachusetts
3254 Workforce Board Association; 1 of whom shall be a representative of the Massachusetts League
3255 of Community Health Centers, Inc.; 1 of whom shall be a representative of the Massachusetts
3256 Medical Society; 1 of whom shall be a representative of the Massachusetts Center for Nursing,
3257 Inc.; 1 of whom shall be a representative of the Massachusetts Nurses Association; 1 of whom
3258 shall be a representative of the Massachusetts Association of Registered Nurses; 1 of whom shall
3259 be a representative of the Massachusetts Hospital Association, Inc.; 1 of whom shall be a
3260 representative from the Massachusetts Association of Physician Assistants; 1 of whom shall be a
3261 representative of the Massachusetts Chiropractic Society; 1 of whom shall be a representative of

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

3268 The council shall meet at least bimonthly, at other times as determined by its rules and
3269 when requested by any 8 members.

3270 (c) The council shall advise the center on: (1) trends in access to primary care and
3271 physician subspecialties, nursing, physician assistant and behavioral, substance use disorder and
3272 mental health services; (2) the development and administration of the loan repayment program,
3273 established under section 25N, including criteria to identify underserved areas in the
3274 commonwealth; and (3) solutions to address identified health care workforces shortages; and (iv)
3275 the center's annual report to the general court.

3276 Section 25N. (a) There shall be a health care workforce loan repayment program,
3277 administered by the health care workforce center established by section 25L. The program shall
3278 provide repayment assistance for graduate and medical school loans to participants who: (1) are
3279 graduates of medical, nursing, or physician assistant schools or accredited graduate schools; (2)
3280 specialize in family health or medicine, internal medicine, pediatrics, obstetrics/gynecology,
3281 psychiatry, behavioral health, mental health or substance use disorder treatment; (3) demonstrate
3282 competency in health information technology, at least equivalent to federal meaningful use
3283 standards as set forth in 45 C.F.R. Part 170, including use of electronic medical records,

3284 computerized physician order entry and e-prescribing; and (4) meet other eligibility criteria,
3285 including service requirements, established by the board.

3286 Each recipient shall be required to enter into a contract with the commonwealth which
3287 shall obligate the recipient to perform a term of service of not less than 2 years in medically
3288 underserved areas as determined by the center.

3289 (b) The center shall promulgate regulations for the administration and enforcement of this
3290 section which shall include penalties and repayment procedures if a participant fails to comply
3291 with the service contract.

3292 The center shall, in consultation with the health care workforce advisory council and the
3293 public health council, establish criteria to identify medically underserved areas within the
3294 commonwealth. These criteria shall consist of quantifiable measures, which may include the
3295 availability of primary care medical services or behavioral, substance use disorder and mental
3296 health services within reasonable traveling distance, poverty levels and disparities in health care
3297 access or health outcomes.

3298 (c) The center shall evaluate the program annually, including exit interviews of
3299 participants to determine their post-program service plans and to solicit program improvement
3300 recommendations.

3301 (d) The center shall file an annual report, not later than July 1, with the governor, the
3302 clerks of the house of representatives and the senate, the house and senate committees on ways
3303 and means, the joint committee on health care financing, the joint committee on mental health
3304 and substance abuse and the joint committee on public health. The report shall include annual
3305 data and historical trends of: (1) the number of applicants, the number accepted and the number

3306 of participants by race, gender, medical, nursing, physician assistant, behavioral health,
3307 substance use, and mental health specialty, graduate, physician assistant, medical or nursing
3308 school, residence prior to graduate, medical, nursing, or physician assistant school and where
3309 they plan to practice after program completion; (2) the service placement locations and length of
3310 service commitments by participants; (3) the number of participants who fail to fulfill the
3311 program requirements and the reason for the failures; (4) the number of former participants who
3312 continue to serve in underserved areas; and (5) program expenditures.

3313 Section 25N 1/2 . (a) As used in this section, “primary care provider”, shall mean a
3314 health care professional qualified to provide general medical care for common health care
3315 problems who: (1) supervises, coordinates, prescribes or otherwise provides or proposes health
3316 care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within
3317 the scope of practice.

3318 (b) Pursuant to regulations to be promulgated by the health care workforce center, there
3319 shall be established a primary care residency grant program for the purpose of financing the
3320 training of primary care providers at teaching community health centers. Eligible applicants shall
3321 include teaching community health centers accredited through affiliations with a commonwealth-
3322 funded medical school or licensed as part of a teaching hospital with a residency program in
3323 primary care or family medicine and teaching health centers that are the independently
3324 accredited sponsoring organization for the residency program and whose residents are employed
3325 by the health center. Eligible residency programs shall be accredited by the Accreditation
3326 Council for Graduate Medical Education.

3327 To receive funding, an applicant shall: (1) include a review of recent graduates of the
3328 community health center's residency program, including information regarding what type of
3329 practice said graduates are involved in 2 years following graduation from the residency program;
3330 and (2) achieve a threshold of at least 50 per cent for the percentage of graduates practicing
3331 primary care within 2 years after graduation. Graduates practicing more than 50 per cent
3332 inpatient care or more than 50 per cent specialty care as listed in the American Medical
3333 Association Masterfile shall not qualify as graduates practicing primary care.

3334 Awardees of the primary care residency grant program shall maintain their teaching
3335 accreditation as either an independent teaching community health center or as a teaching
3336 community health center accredited through affiliation with a commonwealth-funded medical
3337 school or licensed as part of a teaching hospital.

3338 The health care workforce center shall determine through regulation grant amounts per
3339 full-time resident. Funds for such grants shall come from the Health Care Workforce
3340 Transformation Fund established under section 2FFFF of chapter 29.

3341 Section 25N $\frac{3}{4}$. There shall be established a primary care workforce development and
3342 loan forgiveness grant program at community health centers, for the purpose of enhancing
3343 recruitment and retention of primary care physicians and other clinicians at community health
3344 centers throughout the commonwealth. The grant program shall be administered by the
3345 department of public health; provided, that the department may contract with an organization to
3346 administer the grant program. Funds may be matched by other public and private funds.

3347 SECTION 73. Section 25P of said chapter 111 is hereby repealed.

3348 SECTION 74. Section 51 of said chapter 111, as so appearing in the 2010 Official
3349 Edition, is hereby amended by striking out, in line 25 the words “division of health care policy
3350 and finance” and inserting in place thereof the following words:- executive office of health and
3351 human services.

3352 SECTION 75. Said section 51 of said chapter 111, as so appearing, is hereby further
3353 amended by striking out, in lines 36 and 46, the words “division of health care finance and
3354 policy”, each time they appear, and inserting in place thereof, in each instance, the following
3355 words:- center for health information and analysis.

3356 SECTION 76. Said section 51 of said chapter 111, as so appearing, is hereby further
3357 amended by striking out, in lines 27 and 28, the words “pursuant to section 18 of chapter 118G”.

3358 SECTION 77. Section 51G of said chapter 111, as so appearing, is hereby amended by
3359 inserting after the word “ services,” in line 38, the first time it appears, the following words:-
3360 conduct a public hearing on the closure of said essential services or of the hospital. The
3361 department shall.

3362 SECTION 78. Said section 51G of said chapter 111, as so appearing, is hereby further
3363 amended by striking out, in line 40, the word “area,” and inserting in place thereof the following
3364 words:- area and shall.

3365 SECTION 79. Section 51H of said chapter 111, as so appearing, is hereby amended by
3366 striking out subsection (c) and inserting in place thereof the following subsection:-

3367 (c) The department, through interagency service agreements, shall transmit data collected
3368 under this section to the Betsy Lehman center for patient safety and medical error reduction for

3369 publication on the center for health information and analysis consumer health information
3370 website and for reporting quality data to providers. Any facility failing to comply with this
3371 section may: (i) be fined up to \$1,000 per day per violation; (ii) have its license revoked or
3372 suspended by the department; or (iii) be fined up to \$1,000 per day per violation and have its
3373 license revoked or suspended by the department.

3374 SECTION 80. Said chapter 111 is hereby further amended by inserting after section
3375 51H the following 2 sections:–

3376 Section 51I. (a) As used in this section the following words shall, unless the context
3377 clearly requires otherwise, have the following meanings:

3378 “Adverse event”, injury to a patient resulting from a medical intervention and not from
3379 the underlying condition of the patient.

3380 “Checklist of care”, pre-determined steps to be followed by a team of healthcare
3381 providers before, during and after a given procedure to decrease the possibility of adverse effects
3382 and other patient harm by articulating standards of care.

3383 “Facility,” a hospital, an institution maintaining an Intensive Care Unit, an institution
3384 providing surgical services or clinic providing ambulatory surgery.

3385 (b) The department shall encourage the development and implementation of checklists of
3386 care that prevent adverse events and reduce healthcare-associated infection rates. The department
3387 shall develop model checklists of care, which may be implemented by facilities; provided,
3388 however, that facilities may develop and implement checklists independently.

3389 (c) Facilities shall report data and information relative to the use or non-use of checklists
3390 to the department and the Betsy Lehman center for patient safety and medical error reduction.
3391 The department may consider facilities that use similar programs to be in compliance. Reports
3392 shall be made in the manner and form established by the department. The department shall
3393 publicly report on individual hospitals' compliance rates.

3394 Section 51J. The department shall promulgate regulations regarding limited services
3395 clinics. The regulations shall promote the availability of limited services clinics as a point of
3396 access for health care services within the full scope of practice of a nurse practitioner.

3397 Nothing in this section shall be interpreted to allow a limited service clinic to serve as a
3398 patient's primary care provider. Further, nothing in this section shall be interpreted to allow a
3399 limited service clinic to refer patients to a non-primary care provider, unless the limited service
3400 clinic is a satellite of, or is otherwise affiliated with, a health care facility licensed under section
3401 51 or other licensed practitioners and the non-primary care provider practice in the facility or is a
3402 licensed practitioner.

3403 SECTION 81. Section 52 of said chapter 111, as appearing in the 2010 Official Edition,
3404 is hereby amended by inserting after the definition of "Institution for unwed mothers" the
3405 following 2 definitions:-

3406 "Limited services", diagnosis, treatment, management and monitoring of acute and
3407 chronic disease, wellness and preventative services of a nature that may be provided within the
3408 scope of practice of a nurse practitioner using available facilities and equipment, including
3409 shared toilet facilities for point-of-care testing.

3410 "Limited services clinic", a clinic that provides limited services as defined by section 51J.

3411 SECTION 82. Said chapter 111 is hereby further amended by inserting, after section 53G, the
3412 following section:-

3413 Section 53H. No hospital shall enter into a contract or agreement which creates or
3414 establishes a partnership, employment or any other professional relationship with a licensed
3415 physician that would prohibit or limit the ability of that physician to provide testimony in an
3416 administrative or judicial hearing, including cases of medical malpractice.

3417 SECTION 83. Section 62M of said chapter 111, as appearing in the 2010 Official
3418 Edition, is hereby amended by striking out, in line 13, the words “division of health care finance
3419 and policy” and inserting in place thereof the following words:- executive office of health and
3420 human services or a governmental unit designated by the executive office.

3421 SECTION 84. Section 67C of said chapter 111, as so appearing, is hereby amended by
3422 striking out, in line 8, the words “division of health care finance and policy” and inserting in
3423 place thereof the following words:- executive office of health and human services.

3424 SECTION 85. Section 67F of said chapter 111, as so appearing, is hereby amended by
3425 striking out, in lines 15 and 19, the word “physician” and inserting in place thereof, in each
3426 instance, the following word:- provider.

3427 SECTION 86. Section 69H of said chapter 111, as so appearing, is hereby amended by
3428 striking out, in lines 2 and 3, the words “division of health care finance and policy” and inserting
3429 in place thereof the following words:- executive office of health and human services or a
3430 governmental unit designated by the executive office.

3431 SECTION 87. Chapter 111 of the General Laws is hereby amended by inserting after
3432 section 70G the following section:—

3433 Section 70H. Notwithstanding chapter 93A, sections 70E, 72E and 73 and 940 CMR
3434 section 4.09, a facility or institution licensed by the department of public health under section 71
3435 may move a resident to different living quarters or to a different room within the facility or
3436 institution if, as documented in the resident’s clinical record and as certified by a physician, the
3437 resident’s clinical needs have changed such that the resident either: (i) requires specialized
3438 accommodations, care, services, technologies or staffing not customarily provided in connection
3439 with the resident’s living quarters or room; or (ii) ceases to require the specialized
3440 accommodations, care, services, technologies or staffing customarily provided in connection
3441 with the resident’s living quarters or room; provided, however, that nothing in this section shall
3442 obviate a resident's notice and hearing rights when movement to different living quarters
3443 involves a resident moving from a Medicare-certified unit to a non-Medicare-certified unit or
3444 involves a resident moving from a non-Medicare-certified unit to a Medicare-certified unit; and
3445 provided further, that the resident shall have the right to appeal to the facility’s or institution’s
3446 medical director a decision to move the resident to a different living quarter or to a different
3447 room within the facility or institution.

3448 SECTION 88. Section 72P of said chapter 111, as appearing in the 2010 Official Edition,
3449 is hereby amended by striking out, in lines 20 and 21, the words “division of health care finance
3450 and policy” and inserting in place thereof the following words:- center for health information and
3451 analysis.

3452 SECTION 89. Section 72Q of said chapter 111, as so appearing, is hereby amended by
3453 striking out, in lines 2 and 3, the words “division of health care finance and policy” and inserting
3454 in place thereof the following words:- center for health information and analysis.

3455 SECTION 90. Section 72Y of said chapter 111, as so appearing, is hereby amended by
3456 striking out, in lines 43 and 47, the words “7 of chapter 118G” and inserting in place thereof, in
3457 each instance, the following words:- 13D of chapter 118E.

3458 SECTION 91. Section 78 of said chapter 111, as so appearing, is hereby amended by
3459 striking out, in lines 19 and 20, the words “division of health care finance and policy” and
3460 inserting in place thereof the following words:- executive office of health and human services or
3461 a governmental unit designated by the executive office.

3462 SECTION 92. Section 78A of said chapter 111, as so appearing, is hereby amended by
3463 striking out, in line 14, the words “division of health care finance and policy” and inserting in
3464 place thereof the following words:- executive office of health and human services or a
3465 governmental unit designated by the executive office.

3466 SECTION 93. Section 79 of said chapter 111, as so appearing, is hereby amended by
3467 striking out, in line 9, the words “division of health care finance and policy” and inserting in
3468 place thereof the following words:- executive office of health and human services or a
3469 governmental unit designated by the executive office.

3470 SECTION 94. Section 80 of said chapter 111, as so appearing, is hereby amended by
3471 striking out, in lines 5 and 6, the words “division of health care finance and policy” and inserting
3472 in place thereof the following words:- executive office of health and human services or a
3473 governmental unit designated by the executive office.

3474 SECTION 95. Said section 80 of said chapter 111, as so appearing, is hereby further
3475 amended by striking out, in line 8, the word “division” and inserting in place thereof the
3476 following words:- executive office.

3477 SECTION 96. Section 82 of said chapter 111, as so appearing, is hereby amended by
3478 striking out, in lines 22 and 23, the words “division of health care finance and policy” and
3479 inserting in place thereof the following words:- executive office of health and human services or
3480 a governmental unit designated by the executive office.

3481 SECTION 97. Said section 82 of said chapter 111, as so appearing, is hereby further
3482 amended by striking out, in line 24, the word “division” and inserting in place thereof the
3483 following words:- executive office.

3484 SECTION 98. Section 88 of said chapter 111, as so appearing, is hereby amended by
3485 striking out, in line 16, the words “division of health care finance and policy” and inserting in
3486 place thereof the following words:- executive office of health and human services or a
3487 governmental unit designated by the executive office.

3488 SECTION 99. Section 116A of said chapter 111, as so appearing, is hereby amended by
3489 striking out, in line 2, the words “division of health care finance and policy” and inserting in
3490 place thereof the following words:- executive office of health and human services or a
3491 governmental unit designated by the executive office.

3492 SECTION 100. Said chapter 111 is hereby further amended by inserting after section
3493 206 the following section:-

3494 Section 206A. (a) The department, in consultation with the division of insurance, shall
3495 provide a seal of approval to wellness programs implemented by businesses. In developing
3496 criteria for a wellness seal of approval, the department shall consider: (i) actuarial equivalency to
3497 programs under section 206; (ii) whether the program provides new or innovative services; (iii)
3498 the participation rate by employees; (iv) the quality of the health education being provided; (v)
3499 whether the program promotes health screenings and other preventive health care measures; and
3500 (vi) whether the program promotes a healthy workplace environment. For the purposes of this
3501 section, "businesses" shall include professions, sole proprietorships, trades, businesses or
3502 partnerships

3503 (b) The commissioner, in consultation with the commissioner of the department of
3504 revenue, shall create a form that indicates a business is using an approved wellness program.

3505 SECTION 101. Subsection (a) of section 217 of said chapter 111, as appearing in the
3506 2010 Official Edition, is hereby amended by striking out clause (2) and inserting in place thereof
3507 the following clause:-

3508 (2) establish a site on the internet and through other communication media in order to
3509 make managed care information collected by the office readily accessible to consumers. Said
3510 internet site shall, at a minimum, include: (i) a chart, prepared by the office, comparing the
3511 information obtained on premium revenue expended for health care services under clause (3) of
3512 subsection (b) of section 7 of chapter 176O, for the most recent year for which information is
3513 available; and (ii) data collected under subsection (c).

3514 SECTION 102. Said section 217 of said chapter 111, as so appearing, is hereby further
3515 amended by striking out, in lines 48 and 49, the words "the division of health care finance and

3516 policy pursuant to section 24 of chapter 118G” and inserting in place thereof the following
3517 words:- the center for health information and analysis.

3518 SECTION 103. Said chapter 111 is hereby further amended by adding the following 4
3519 sections:—

3520 Section 225. (a) For the purposes of this section, the following words shall, unless the
3521 context clearly requires otherwise, have the following meanings:

3522 “Anatomic pathology service”, histopathology, surgical pathology, cytopathology,
3523 hematology, subcellular pathology, molecular pathology and blood-banking services performed
3524 by a pathologist.

3525 “Charge”, the uniform price for specific services within a revenue center of a hospital.

3526 “Cytopathology”, the examination of cells from the following:

3527 (i) fluids;

3528 (ii) aspirates;

3529 (iii) washings;

3530 (iv) brushings; or

3531 (v) smears, including the pap test examination performed by a physician or under
3532 the supervision of a physician.

3533 “Hematology”, the microscopic evaluation of bone marrow aspirates and biopsies
3534 performed by a physician or under the supervision of a physician, and peripheral blood smears

3535 when the attending or treating physician or technologist requests that a blood smear be reviewed
3536 by a pathologist.

3537 “Histopathology” or “surgical pathology”, the gross and microscopic examination of
3538 organ tissue performed by a physician or under the supervision of a physician.

3539 “Patient”, any natural person receiving health care services.

3540 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
3541 patient for a charge.

3542 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX of
3543 the federal Social Security Act programs, other governmental payers, insurance companies,
3544 health maintenance organizations and nonprofit hospital service corporations. Third party payer
3545 shall not include a purchaser responsible for payment for health care services rendered by a
3546 hospital, either to the purchaser or to the hospital.

3547 (b) A clinical laboratory or physician providing anatomic pathology services for patients
3548 in the commonwealth shall present or cause to be presented a claim, bill or demand for payment
3549 for these services only to the following:

3550 (i) the patient directly;

3551 (ii) the responsible insurer or other third-party payer;

3552 (iii) the hospital, public health clinic or nonprofit health clinic ordering such
3553 services;

3554 (iv) the referral laboratory or a physician's office laboratory when the physician
3555 of such laboratory performs the anatomic pathology service; or

3556 (v) the governmental agency or its specified public or private agent, agency or
3557 organization on behalf of the recipient of the services.

3558 (c) Except as provided under this section, no licensed practitioner shall, directly or
3559 indirectly, charge, bill or otherwise solicit payment for anatomic pathology services unless the
3560 services were rendered personally by the licensed practitioner or under the licensed practitioner's
3561 direct supervision under section 353 of the Public Health Service Act, 42 U.S.C. § 263a.

3562 (d) No patient, insurer, third party payer, hospital, public health clinic or non-profit health
3563 clinic shall be required to reimburse any licensed practitioner for charges or claims submitted in
3564 violation of this section.

3565 (e) Nothing in this section shall be construed to mandate the assignment of benefits for
3566 anatomic pathology services.

3567 (f) Nothing in this section shall prohibit billing between laboratories for anatomic
3568 pathology services in instances where a sample must be sent to another specialist. Nothing in this
3569 section shall authorize a physician's office laboratory to bill for anatomic pathology services
3570 when the physician of such laboratory has not performed the anatomic pathology service.

3571 (g) The board of registration in medicine may revoke, suspend or deny renewal of the
3572 license of a practitioner who violates this section.

3573 Section 226. For purposes of this section, "mandatory overtime" shall mean any hours
3574 worked by a nurse in a hospital setting to deliver patient care, beyond the predetermined and

3575 regularly scheduled number of hours that the hospital and nurse have agreed that the employee
3576 shall work, provided that in no case shall such predetermined and regularly scheduled number of
3577 hours exceed 12 hours in any 24 hour period.

3578 (b) Notwithstanding any general or special law to the contrary, a hospital shall not require
3579 a nurse to work mandatory overtime except in the case of an emergency situation where the
3580 safety of the patient requires its use and when there is no reasonable alternative.

3581 (c) Under subsection (b), whenever there is an emergency situation where the safety of a
3582 patient requires its use and when there is no reasonable alternative, the facility shall, before
3583 requiring mandatory overtime, make a good faith effort to have overtime covered on a voluntary
3584 basis. Mandatory overtime shall not be used as a practice for providing appropriate staffing for
3585 the level of patient care required.

3586 (d) Under subsection (c), the health policy commission established under section 2 of
3587 chapter 6D, shall develop guidelines and procedures to determine what constitutes an emergency
3588 situation for the purposes of allowing mandatory overtime. In developing those guidelines, the
3589 commission shall consult with those employees and employers who would be affected by such a
3590 policy. The Commission shall solicit comment from those same parties through a public hearing.

3591 (e) Hospitals shall report all instances of mandatory overtime and the circumstances
3592 requiring its use to the department of public health. Such reports shall be public documents.

3593 (f) A nurse shall not be allowed to exceed 16 consecutive hours worked in a 24 hour
3594 period. In the event a nurse works 16 consecutive hours, that nurse must be given at least 8
3595 consecutive hours of off-duty time immediately after the worked overtime.

3596 (g) This section is intended as a remedial measure to protect the public health and the
3597 quality and safety of patient care and shall not be construed to diminish or waive any rights of
3598 the nurse under other laws, regulations or collective bargaining agreements. The refusal of a
3599 nurse to accept work in excess of the limitations set forth in this section shall not be grounds for
3600 discrimination, dismissal, discharge or any other employment decision.

3601 (h) Nothing in this section shall be construed to limit, alter or modify the terms,
3602 conditions or provisions of a collective bargaining agreement entered into by a hospital and a
3603 labor organization.

3604 Section 227. (a) As used in this section the following terms shall, unless the context
3605 clearly requires otherwise, have the following meanings:

3606 “Appropriate”, consistent with applicable legal, health and professional standards, the
3607 patient’s clinical and other circumstances and the patient’s reasonably known wishes and beliefs.

3608 “Attending health care practitioner”, a physician or nurse practitioner who has primary
3609 responsibility for the care and treatment of the patient; provided that if more than 1 physician or
3610 nurse practitioner share that responsibility, each of them shall have a responsibility under this
3611 section, unless there is an agreement to assign that responsibility to 1 such person.

3612 “Palliative care”, a health care treatment, including interdisciplinary end-of-life care and
3613 consultation with patients and family members, to prevent or relieve pain and suffering and to
3614 enhance the patient’s quality of life, including hospice care.

3615 “Terminal illness or condition”, an illness or condition which can reasonably be expected
3616 to cause death within 6 months, whether or not treatment is provided.

3617 (b) The commissioner shall adopt regulations requiring each licensed hospital, skilled
3618 nursing facility, health center or assisted living facility to distribute to appropriate patients in its
3619 care information regarding the availability of palliative care and end-of-life options.

3620 (c) If a patient is diagnosed with a terminal illness or condition, the patient's attending
3621 health care practitioner shall offer to provide the patient with information and counseling
3622 regarding palliative care and end-of-life options appropriate for the patient, including, but not
3623 limited to: (i) the range of options appropriate for the patient; (ii) the prognosis, risks and
3624 benefits of the various options; and (iii) the patient's legal rights to comprehensive pain and
3625 symptom management at the end-of-life. The information and counseling may be provided orally
3626 or in writing. Where the patient lacks capacity to reasonably understand and make informed
3627 choices relating to palliative care, the attending health care practitioner shall provide information
3628 and counseling under this section to a person with authority to make health care decisions for
3629 that patient. The attending health care practitioner may arrange for information and counseling
3630 under this section to be provided by another professionally qualified individual.

3631 If the attending health care practitioner is not willing to provide the patient with
3632 information and counseling under this section, the attending health care practitioner shall arrange
3633 for another physician or nurse practitioner to do so or shall refer or transfer the patient to another
3634 physician or nurse practitioner willing to do so.

3635 Nothing in this section shall be construed to permit a healthcare professional to offer to
3636 provide information about assisted suicide or the prescribing of medication to end life.

3637 (d) The department shall consult with the Hospice and Palliative Care Federation of
3638 Massachusetts in developing educational documents, rules and regulations related to this section.

3639 Section 228. (a) Prior to an admission, procedure or service and upon request by a
3640 patient or prospective patient, a health care provider shall, within 2 working days, disclose the
3641 allowed amount or charge of the admission, procedure or service, including the amount for any
3642 facility fees required; provided, however, that if a health care provider is unable to quote a
3643 specific amount in advance due to the health care provider's inability to predict the specific
3644 treatment or diagnostic code, the health care provider shall disclose the estimated maximum
3645 allowed amount or charge for a proposed admission, procedure or service, including the amount
3646 for any facility fees required.

3647 (b) If a patient or prospective patient is covered by a health plan, a health care provider
3648 who participates as a network provider shall, upon request of a patient or prospective patient,
3649 provide, based on the information available to the provider at the time of the request, sufficient
3650 information regarding the proposed admission, procedure or service for the patient or prospective
3651 patient to use the applicable toll-free telephone number and website of the health plan established
3652 to disclose out-of-pocket costs, under section 23 of chapter 176O. A health care provider may
3653 assist a patient or prospective patient in using the health plan's toll-free number and website.

3654 (b) A health care provider referring a patient to another provider that is part of or
3655 represented by the same provider organization as defined in section 11 of chapter 6D shall
3656 disclose that the providers are part of or represented by the same provider organization.

3657 As used in this section, "allowed amount", shall mean the contractually agreed upon
3658 amount paid by a carrier to a health care provider for health care services provided to an insured.

3659 SECTION 104. Section 1 of chapter 111K of the General Laws, as appearing in the 2010
3660 Official Edition, is hereby amended by striking out, in lines 7 and 8, the words “established by
3661 section 18 of chapter 118G”.

3662 SECTION 105. Section 10 of said chapter 111K, as so appearing, is hereby amended by
3663 striking out, in lines 2 and 3, the words “division of health care finance and policy”, and inserting
3664 in place thereof the following words:- center for health information and analysis.

3665 SECTION 106. Section 3 of chapter 111M of the General Laws, as so appearing, is
3666 hereby amended by striking out, in line 10, the words “division of health care finance and
3667 policy” and inserting in place thereof the following words:- center for health information and
3668 analysis.

3669 SECTION 107. Said section 3 of said chapter 111M, as so appearing, is hereby further
3670 amended by striking out, in line 11, the word “division” and inserting in place thereof the
3671 following word:- center.

3672 SECTION 108. The first paragraph of section 2 of chapter 112 of the General Laws, as so
3673 appearing, is hereby amended by inserting after the second sentence the following 2
3674 sentences:—The board shall require, as a standard of eligibility for licensure, that applicants
3675 demonstrate proficiency in the use of computerized physician order entry, e-prescribing,
3676 electronic health records and other forms of health information technology, as determined by the
3677 board. As used in this section, proficiency, at a minimum shall mean that applicants demonstrate
3678 the skills to comply with the “meaningful use” requirements, as set forth in 45 C.F.R. Part 170.

3679 SECTION 109. Said chapter 112 is hereby further amended by inserting, after section 2C,
3680 the following section:-

3681 Section 2D. No physician shall enter into a contract or agreement which creates or
3682 establishes a partnership, employment or any other form of professional relationship that
3683 prohibits a physician from providing testimony in an administrative or judicial hearing, including
3684 cases of medical malpractice.

3685 SECTION 110. Section 9C of said chapter 112, as appearing in the 2010 Official
3686 Edition, is hereby amended by striking out the definition of “Physician assistant” and inserting in
3687 place thereof the following definition:-

3688 “Physician assistant,” a person who is duly registered and licensed by the board.

3689 SECTION 111. The first paragraph of section 9E of said chapter 112 , as so appearing, is
3690 hereby amended by striking out the last sentence.

3691 SECTION 112. The third paragraph of said section 9E of said chapter 112, as so
3692 appearing, is hereby amended by striking out the last sentence.

3693 SECTION 113. Said chapter 112 is hereby further amended by inserting after section
3694 80H the following section:—

3695 Section 80I. When a law or rule requires a signature, certification, stamp, verification,
3696 affidavit or endorsement by a physician, when relating to physical or mental health, that
3697 requirement may be fulfilled by a nurse practitioner practicing under section 80B. Nothing in
3698 this section shall be construed to expand the scope of practice of nurse practitioners. This
3699 section shall not be construed to preclude the development of mutually agreed upon guidelines
3700 between the nurse practitioner and supervising physician under section 80E.

3701 SECTION 114. Section 8 of chapter 118E of the General Laws, as appearing in the 2010
3702 Official Edition, is hereby amended by inserting after clause e the following paragraph:-

3703 e1/2. “Primary care provider”, a health care professional qualified to provide general
3704 medical care for common health care problems who: (i) supervises, coordinates, prescribes or
3705 otherwise provides or proposes health care services; (ii) initiates referrals for specialist care; and
3706 (iii) maintains continuity of care within the scope of practice.

3707 SECTION 115. Said chapter 118E is hereby amended by inserting after section 8 the
3708 following section:—

3709 Section 8A. For the purposes of sections 13C to 13K, inclusive, and sections 64 to 70,
3710 inclusive, the following terms and phrases shall, unless the context clearly requires otherwise,
3711 have the following meanings:

3712 “Actual costs”, all direct and indirect costs incurred by a hospital or a community health
3713 center in providing medically necessary care and treatment to its patients, determined in
3714 accordance with generally accepted accounting principles.

3715 “Acute hospital”, the teaching hospital of the University of Massachusetts Medical
3716 School and any hospital licensed under section 51 of chapter 111 and which contains a majority
3717 of medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of
3718 public health.

3719 “Case mix”, the description and categorization of a hospital’s patient population
3720 according to criteria approved by the center for health information and analysis including, but

3721 not limited to, primary and secondary diagnoses, primary and secondary procedures, illness
3722 severity, patient age and source of payment.

3723 “Charge”, the uniform price for specific services within a revenue center of a hospital.

3724 “Child”, a person who is under 18 years of age.

3725 “Community health centers”, health centers operating in conformance with Section 330
3726 of United States Public Law 95-626 and shall include all community health centers which file
3727 cost reports as requested by the center.

3728 “Comprehensive cancer center”, the hospital of any institution so designated by the
3729 national cancer institute organized solely for the treatment of cancer, and offered exemption from
3730 the Medicare diagnosis related group payment system.

3731 “Disproportionate share hospital”, an acute hospital that exhibits a payer mix where a
3732 minimum of 63 per cent of the acute hospital’s gross patient service revenue is attributable to
3733 Title XVIII and Title XIX of the federal Social Security Act, other government payers and free
3734 care.

3735 “Emergency medical condition”, a medical condition, whether physical or mental,
3736 manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of
3737 prompt medical attention could reasonably be expected by a prudent layperson who possesses an
3738 average knowledge of health and medicine, to result in placing the health of the person or
3739 another person in serious jeopardy, serious impairment to body function or serious dysfunction
3740 of any body organ or part or, with respect to a pregnant woman, as further defined in 42 U.S.C.
3741 section 1395dd(e)(1)(B).

3742 “Emergency services”, medically necessary health care services provided to an individual
3743 with an emergency medical condition.

3744 “Employee”, a person who performs services primarily in the commonwealth for
3745 remuneration for a commonwealth employer; provided, that “employee” shall not include a
3746 person who is self-employed.

3747 “Employer”, an employer as defined in section 1 of chapter 151A.

3748 “Enrollee”, a person who becomes a member of an insurance program of the division
3749 either individually or as a member of a family.

3750 “Financial requirements”, a hospital’s requirement for revenue which shall include, but
3751 not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of
3752 depreciation of plant and equipment and the reasonable costs associated with changes in medical
3753 practice and technology.

3754 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
3755 ends in the calendar year by which it is identified.

3756 “Free care”, the following medically necessary services provided to individuals
3757 determined to be financially unable to pay for care, in whole or in part, under applicable
3758 regulations of the executive office: (i) services provided by acute hospitals; (ii) services provided
3759 by community health centers; and (iii) patients in situations of medical hardship in which major
3760 expenditures for health care have depleted or can reasonably be expected to deplete the financial
3761 resources of the individual to the extent that medical services cannot be paid, as determined by
3762 regulations of the executive office.

3763 “General health supplies, care or rehabilitative services and accommodations”, all
3764 supplies, care and services of medical, optometric, dental, surgical, podiatric, psychiatric,
3765 therapeutic, diagnostic, rehabilitative, supportive or geriatric nature, including inpatient and
3766 outpatient hospital care and services and accommodations in hospitals, sanatoria, infirmaries,
3767 convalescent and nursing homes, retirement homes, facilities established, licensed or approved
3768 under chapter 111B and providing services of a medical or health-related nature and similar
3769 institutions including those providing treatment, training, instruction and care of children and
3770 adults; provided, however, that rehabilitative service shall include only rehabilitative services of
3771 a medical or health-related nature which are eligible for reimbursement under Title XIX of the
3772 federal Social Security Act.

3773 “Governmental mandate”, a state or federal statutory requirement, administrative rule,
3774 regulation, assessment, executive order, judicial order or other governmental requirement that
3775 directly or indirectly imposes an obligation and associated compliance cost upon a provider to
3776 take an action or to refrain from taking an action in order to fulfill the provider’s contractual duty
3777 to a procuring governmental unit.

3778 “Governmental unit”, the commonwealth, any department, agency board, commission or
3779 political subdivision of the commonwealth.

3780 “Gross patient service revenue”, the total dollar amount of a hospital’s charges for
3781 services rendered in a fiscal year.

3782 “Health care services”, supplies, care and services of a medical, surgical, optometric,
3783 dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative,
3784 supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital

3785 care and services, services provided by a community health center or by a sanatorium, included
3786 in the definition of “hospital” in Title XVIII of the federal Social Security Act and treatment and
3787 care compatible with such services or by a health maintenance organization.

3788 “Health insurance company”, a company as defined in section 1 of chapter 175 which
3789 engages in the business of health insurance.

3790 “Health insurance plan”, the Medicare program or an individual or group contract or
3791 other plan providing coverage of health care services and which is issued by a health insurance
3792 company, a hospital service corporation, a medical service corporation or a health maintenance
3793 organization.

3794 “Health maintenance organization”, a company which provides or arranges for health
3795 care services to enrolled members in exchange primarily for a prepaid per capita or aggregate
3796 fixed sum as defined in section 1 of chapter 176G.

3797 “Hospital”, a hospital licensed under section 51 of chapter 111, the teaching hospital of
3798 the University of Massachusetts Medical School and any psychiatric facility licensed under
3799 section 19 of chapter 19.

3800 “Medical assistance program”, the Medicaid program, the Veterans Administration health
3801 and hospital programs and any other medical assistance program operated by a governmental
3802 unit for persons categorically eligible for such program.

3803 “Medically necessary services”, medically necessary inpatient and outpatient services as
3804 mandated under Title XIX of the federal Social Security Act. Medically necessary services shall
3805 not include: (i) non-medical services, such as social, educational and vocational services; (ii)

3806 cosmetic surgery; (iii) canceled or missed appointments; (iv) telephone conversations and
3807 consultations; (v) court testimony; (vi) research or the provision of experimental or unproven
3808 procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-
3809 surgery hormone therapy; and (vii) providing whole blood; provided, however, that
3810 administrative and processing costs associated with providing blood and its derivatives shall be
3811 payable.

3812 “Medicare program”, the medical insurance program established by Title XVIII of the
3813 federal Social Security Act.

3814 “Non-acute hospital”, a hospital which is not an acute hospital.

3815 “Patient”, a natural person receiving health care services from a hospital.

3816 “Pediatric hospital”, an acute care hospital which limits services primarily to children and
3817 which qualifies as exempt from the Medicare Prospective Payment system regulations.

3818 “Pediatric specialty unit”, a pediatric unit of an acute care hospital in which the ratio of
3819 licensed pediatric beds to total licensed hospital beds as of July 1, 1994, exceeded 0.20. In
3820 calculating that ratio, licensed pediatric beds shall include the total of all pediatric service beds
3821 and the total of all licensed hospital beds shall include the total of all licensed acute care hospital
3822 beds, consistent with Medicare’s acute care hospital reimbursement methodology as put forth in
3823 the Provider Reimbursement Manual Part 1, Section 2405.3G.

3824 “Provider”, any person, corporation partnership, governmental unit, state institution or
3825 any other entity qualified under the laws of the commonwealth to perform or provide health care
3826 services.

3827 “Publicly aided patient”, a person who receives hospital care and services for which a
3828 governmental unit is liable, in whole or in part, under a statutory program of public assistance.

3829 “Purchaser”, a natural person responsible for payment for health care services rendered
3830 by a hospital.

3831 “Resident”, a person living in the commonwealth, as defined by the executive office
3832 through a regulation; provided, however, that such regulation shall not define a resident as a
3833 person who moved into the commonwealth for the sole purpose of securing health insurance
3834 under this chapter; and provided, further that confinement of a person in a nursing home, hospital
3835 or other medical institution shall not in and of itself, suffice to qualify such person as a resident.

3836 “Revenue center”, a functioning unit of a hospital which provides distinctive services to a
3837 patient for a charge.

3838 “Self-employed”, a person who, at common law, is not considered to be an employee and
3839 whose primary source of income is derived from the pursuit of a bona fide business.

3840 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
3841 business, which is not a health insurance plan and in which the business is liable for the actual
3842 costs of the health care services provided by the plan and administrative costs.

3843 “Social service program”, a social, mental health, developmental disabilities, habilitative,
3844 rehabilitative, substance abuse, residential care, adult or adolescent day care, vocational,
3845 employment and training or elder service program or accommodations purchased by a
3846 governmental unit or political subdivision of the executive office of health and human services,
3847 but excluding any program, service or accommodation that: (i) is reimbursable under a Medicaid

3848 waiver granted under section 1115 of Title XI of the federal Social Security Act; or (ii) is funded
3849 exclusively by a federal grant.

3850 “Social service program provider”, a provider of social service programs in the
3851 commonwealth.

3852 “Sole community provider”, any acute hospital which qualifies as a sole community
3853 provider under Medicare regulations or under regulations promulgated by the executive office.
3854 Those regulations shall consider factors including, but not limited to, isolated location, weather
3855 conditions, travel conditions, percentage of Medicare, Medicaid and free care provided and the
3856 absence of other reasonably accessible hospitals in the area; provided, that such hospitals shall
3857 include those which are located more than 25 miles from other such hospitals in the
3858 commonwealth and which provide services for at least 60 per cent of the primary service area.

3859 “Specialty hospital”, an acute hospital which qualifies for an exemption from the
3860 Medicare prospective payment system regulations or an acute hospital which limits its
3861 admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to
3862 children or patients under obstetrical care.

3863 “State institution”, a hospital, sanatorium, infirmary, clinic and other such facility owned,
3864 operated or administered by the commonwealth which furnishes general health supplies, care or
3865 rehabilitative services and accommodations.

3866 “Third party payer”, an entity including, but not limited to, Title XVIII and Title XIX
3867 programs, other governmental payers, insurance companies, health maintenance organizations
3868 and nonprofit hospital service corporations; provided, however, that “third party payer” shall not

3869 include a purchaser responsible for payment for health care services rendered by a hospital,
3870 either to the purchaser or to the hospital.

3871 SECTION 116. Section 9C of said chapter 118E, as appearing in the 2010 Official
3872 Edition, is hereby amended by striking out, in line 145, the words “established by subsection (c)
3873 of section 18 of chapter 118G”.

3874 SECTION 117. Saidn chapter 118E is hereby further amended by inserting after section
3875 9E the following section:-

3876 Section 9F. (a) As used in this section, the following words shall, unless the context
3877 clearly requires otherwise, have the following meanings:

3878 “Dual eligible”, or “dually eligible person”, any person age 21 or older and under age 65
3879 who is enrolled in both Medicare and MassHealth.

3880 “Integrated care organization” or “ICO”, a comprehensive network of medical, health
3881 care and long-term services and supports providers that integrates all components of care, either
3882 directly or through subcontracts and has been contracted with by the executive office of health
3883 and human services and designated an ICO to provide services to dually eligible individuals
3884 under this section.

3885 (b) Members of the MassHealth dual eligible pilot program on ICOs or any successor
3886 program integrating care for dual eligible persons shall be provided an independent community
3887 care coordinator by the ICO or successor organization, who shall be a participant in the
3888 member’s care team. The community care coordinator shall assist in the development of a long-
3889 term support and services care plan. The community care coordinator shall:

3890 (1) participate in initial and ongoing assessments of the health and functional
3891 status of the member, including determining appropriateness for long-term care support and
3892 services, either in the form of institutional or community-based care plans and related service
3893 packages necessary to improve or maintain enrollee health and functional status;

3894 (2) arrange and, with the agreement of the member and the care team, coordinate
3895 appropriate institutional and community long-term supports and services, including assistance
3896 with the activities of daily living and instrumental activities of daily living, housing, home-
3897 delivered meals, transportation and, under specific conditions or circumstances established by
3898 the ICO or successor organization, authorize a range and amount of community-based services;
3899 and

3900 (3) monitor the appropriate provision and functional outcomes of community
3901 long-term care services, according to the service plan as deemed appropriate by the member and
3902 the care team; and track member satisfaction and the appropriate provision and functional
3903 outcomes of community long-term care services, according to the service plan as deemed
3904 appropriate by the member and the care team.

3905 (c) The ICO or successor organization shall not have a direct or indirect financial
3906 ownership interest in an entity that serves as an independent care coordinator. Providers of
3907 institutional or community based long-term services and supports on a compensated basis shall
3908 not function as an independent care coordinator; provided, however, that the secretary may grant
3909 a waiver of this restriction upon a finding that public necessity and convenience require such a
3910 waiver. For the purposes of this section, an organization compensated to provide only evaluation,

3911 assessment, coordination, skills training, peer supports and fiscal intermediary services shall not
3912 be considered a provider of long term services and supports.

3913 SECTION 118. Section 12 of said chapter 118E, as appearing in the 2010 Official
3914 Edition, is hereby amended by striking out, in lines 11 and 12, the words “division of health care
3915 finance and policy” and inserting in place thereof the following words:- center for health
3916 information and analysis.

3917 SECTION 119. Section 13 of said chapter 118E, as so appearing, is hereby amended by
3918 striking out, in lines 3 and 4, the words “division of health care finance and policy established by
3919 chapter one hundred and eighteen G, which shall be called the “division” only for the purposes
3920 of this section and inserting in place thereof the following words:- executive office of health and
3921 human services, which shall be called the “executive office” only for the purposes of this section
3922 or by a governmental unit designated by the executive office.

3923 SECTION 120. Said section 13 of said chapter 118E, as so appearing, is hereby further
3924 amended by striking out, in lines, 9, 15, 18, 20, 22 and 33 the word “division” and inserting in
3925 place thereof, in each instance, the following words:- executive office.

3926 SECTION 121. Said section 13 of said chapter 118E, as so appearing, is hereby further
3927 amended by striking out, in line 25, the word “division” and inserting in place thereof the
3928 following words:- center for health information and analysis.

3929 SECTION 122. Section 13B of said chapter 118E, as so appearing, is hereby further
3930 amended by striking out, in lines 11 and 12, the words “the Massachusetts health care quality and
3931 cost council, established under section 16K of chapter 6A and”.

3932 SECTION 123. Said chapter 118E is hereby amended by inserting after section 13B the
3933 following 10 sections:-

3934 Section 13C. The secretary of the executive office shall establish rates of payment for
3935 health care services; provided, that the secretary may designate another governmental unit to
3936 perform such ratemaking functions. The secretary of the executive office shall have the
3937 responsibility for establishing rates to be paid to providers for health care services by
3938 governmental units, including the division of industrial accidents. The rates shall be adequate to
3939 meet the costs incurred by efficiently and economically operated facilities providing care and
3940 services in conformity with applicable state and federal laws and regulations and quality and
3941 safety standards and which are within the financial capacity of the commonwealth.
3942 Notwithstanding any general or special law or rule or regulation to the contrary, the secretary of
3943 the executive office shall have the responsibility for establishing fair and adequate charges to be
3944 used by state institutions for general health supplies, care and rehabilitative services and
3945 accommodations, which charges shall be based on the actual costs of the state institution
3946 reasonably related, in the circumstances of each institution, to the efficient production of the
3947 services in the institution and shall also have sole responsibility for determining rates paid for
3948 educational assessments conducted or performed by psychologists and trained, certified
3949 educational personnel under the tenth paragraph of section 3 of chapter 71B.

3950 The secretary of the executive office shall have the responsibility for establishing rates of
3951 payment for social service programs which are reasonable and adequate to meet the costs which
3952 are incurred by efficiently and economically operated social service program providers in
3953 providing social service programs in conformity with federal and state law, regulations and
3954 quality and safety standards; provided, that the secretary may designate another governmental

3955 unit to perform such ratemaking functions. When establishing rates of payment for social service
3956 programs, the secretary of the executive office shall adjust rates to take into account factors,
3957 including, but not limited to: (i) the reasonable cost to social service program providers of any
3958 existing or new governmental mandate that has been enacted, promulgated or imposed by any
3959 governmental unit or federal governmental authority; (ii) a cost adjustment factor to reflect
3960 changes in reasonable costs of goods and services of social service programs including those
3961 attributed to inflation; and (iii) geographic differences in wages, benefits, housing and real estate
3962 costs in each metropolitan statistical area of the commonwealth and in any city or town therein
3963 where such costs are substantially higher than the average cost within that area as a whole. The
3964 secretary of the executive office shall not consider any of the resources specified in section 13G
3965 when establishing, reviewing or approving rates of payment for social service programs.

3966 Section 13D. The executive office, or a governmental unit designated to perform
3967 ratemaking functions by the executive office shall: (i) determine, after public hearing, at least
3968 annually for institutional providers, and at least biennially for non-institutional providers, the
3969 rates to be paid by each governmental unit to providers of health care services and social service
3970 programs, provided, however, that for the purposes of this section, social service program
3971 providers shall be treated as non-institutional providers; (ii) determine, after public hearing, at
3972 least annually, the rates to be charged by each state institution for general health supplies, care or
3973 rehabilitative services and accommodations; (iii) certify to each affected governmental unit the
3974 rates so determined; (iv) determine, after public hearing, at least annually, and certify to the
3975 division of industrial accidents of the department of labor and industries, rates of payment for
3976 general health supplies, care or rehabilitative services and accommodations, which rates shall be
3977 paid for services under chapter 152; (v) upon request of the division of insurance, assist the

3978 division of insurance in the performance of its duties as set forth in section 4 of chapter 176B;
3979 and (vi) may establish fair and reasonable classifications upon which any rates may be based for
3980 rest homes, nursing homes and convalescent homes; provided, however, that the executive office
3981 shall not cause a decrease in a rate or add a penalty to a rate because such home has an equity
3982 position which is less than 0.

3983 Such rates for nursing homes and rest homes, as defined under section 71 of chapter 111,
3984 shall be established as of October 1 of each year. In setting such rates, the executive office shall
3985 use as base year costs for rate determination purposes the reported costs of the calendar year not
3986 more than 4 years prior to the current rate year, adjusted for reasonableness and to incorporate
3987 any audit findings applicable to said base year costs. In any appeal of rates under section 13E,
3988 the petitioner shall not be permitted to introduce into the records of such an appeal evidence of
3989 costs for any year other than the base year used to establish the rate. Notwithstanding any other
3990 general or special law or regulation to the contrary, except as provided in this chapter, each
3991 governmental unit shall pay to a provider of services and each state institution shall charge as a
3992 provider of health care services, as the case may be, the rates for general health supplies, care
3993 and rehabilitative services and accommodations determined and certified by the executive office.
3994 In establishing rates of payment to providers of services, the executive office shall control rate
3995 increases and shall impose such methods and standards as are necessary to ensure reimbursement
3996 for those costs which must be incurred by efficiently and economically operated facilities and
3997 providers. Such methods and standards may include, but shall not be limited to, the following:
3998 peer group cost analyses; ceilings on capital and operating costs; productivity standards; caps or
3999 other limitations on the utilization of temporary nursing or other personnel services; use of
4000 national or regional indices to measure increases or decreases in reasonable costs; limits on

4001 administrative costs associated with the use of management companies; the availability of
4002 discounts for large volume purchasers; the revision of existing historical cost bases, where
4003 applicable, to reflect norms or models of efficient service delivery; and other means to encourage
4004 the cost-efficient delivery of services. Rates produced using these methods and standards shall be
4005 in conformance with Title XIX, including the upper limit on provider payments.

4006 In determining rates to be paid by governmental units to providers of services, the
4007 executive office shall include as an operating expense of a provider of services any contribution
4008 made in lieu of taxes by such provider of services to a city or town and shall establish by
4009 regulation those expenses treated as business deductions under the Internal Revenue Code, which
4010 shall be included as allowable operating expenses in determining rates of reimbursement. Except
4011 for ceilings or maximum rates of reimbursement, which are determined in accordance with rate
4012 determination methods imposed on nursing homes, any ceiling or maximum imposed by the
4013 executive office upon the rate of reimbursement to be paid to rest homes shall reflect the actual
4014 costs of rest home providers and shall not prevent any such rest home provider from receiving
4015 full payment for costs necessarily incurred in the provision of services in compliance with
4016 federal or state regulations and requirements.

4017 In determining rates to be paid by governmental units to acute-care hospitals, as defined
4018 in section 25B of chapter 111, and any hospital or separate unit of a hospital that provides acute
4019 psychiatric services, as defined in said section 25B, the executive office shall include as an
4020 operating expense the reasonable cost of providing competent interpreter services as required by
4021 section 25J of said chapter 111 or section 23A of chapter 123.

4022 No hospital shall receive reimbursement or payment from any governmental unit for
4023 amounts paid to employees, as salary, or to consultant or other firms, as fees, where the primary
4024 responsibility of the employees or consultants is, either directly or indirectly, to persuade or seek
4025 to persuade the employees of the hospital to support or oppose unionization. Attorney's fees for
4026 services rendered in dealing directly with a union, in advising hospital management of its
4027 responsibilities under the National Labor Relations Act, or for services at an administrative
4028 agency or court or for services by an attorney in preparation for the agency or in court
4029 proceeding shall not be support or opposition to unionization.

4030 The executive office shall establish rates on a prospective basis, subject to rules and
4031 regulations promulgated by the executive office.

4032 In establishing rates for nursing pools under section 72Y of chapter 111, the executive
4033 office shall establish annually the limit for the rate for service provided by nursing pools to
4034 licensed facilities. The executive office shall establish industry-wide class rates for such services
4035 and shall establish separate class rates for services provided to nursing facilities and hospitals.
4036 The executive office shall establish separate rates for registered nurses, licensed practical nurses
4037 and certified nursing assistants. The executive office may establish rates by geographic region.
4038 The rates shall include an allowance for wages, payroll taxes and fringe benefits, which shall be
4039 based upon, and shall not exceed, median wages, payroll taxes and fringe benefits paid to
4040 permanent medical personnel of the same type at health care facilities in the same geographic
4041 region. The rates shall also include an allowance for reasonable administrative expenses and a
4042 reasonable profit factor, as determined by the executive office. The executive office may exempt
4043 from the rates certain categories, as defined by the executive office, of fixed-term employees that
4044 work exclusively at a particular health care facility for a period of at least 90 days and for whose

4045 services there is a contract between a facility and a nursing pool registered with the department
4046 of public health. The executive office shall establish procedures by which nursing pools shall
4047 submit cost reports, which may be subject to audit, to the executive office to establish rates. The
4048 executive office shall determine the nursing pool rate contained in this paragraph by considering
4049 wage and benefit data collected from cost reports received from nursing pools and from health
4050 care facilities and other relevant information gathered through other collection tools or
4051 reasonable methodologies.

4052 Except as otherwise provided in this section any person aggrieved by any rate
4053 determination made under this section shall have a right of appeal as provided under section 13E.

4054 The executive office may enter into such contracts or agreements with the federal
4055 government, a political subdivision of the commonwealth or any public or private corporation or
4056 organization, as it deems necessary; provided, however, that the executive office shall not enter
4057 into any contract or agreement with a private corporation or organization to furnish information
4058 and statistical data to be used by said executive office as its sole basis for setting rates, if such
4059 private corporation or organization is to make or receive payments based upon the rates so set.

4060 Each governmental unit shall cooperate with the executive office at all times in the
4061 furtherance of the executive office's purposes. Each state institution shall permit the executive
4062 office or any designated representatives of the executive office, to examine its books and
4063 accounts and shall file with the executive office from time to time or upon request such data,
4064 statistics, schedules or other information as the executive office may reasonably require.

4065 Each rate established by the executive office shall be a regulation and shall be subject to
4066 review as hereinafter provided. The executive office shall promulgate rules and regulations for

4067 the administration of its duties and the determination of rates as are herein required subject to the
4068 procedures prescribed by chapter 30A. Every rate, classification and other regulation established
4069 by the executive office shall be consistent where applicable with the principles of reimbursement
4070 for provider costs in effect from time to time under Titles XVIII and XIX of the federal Social
4071 Security Act governing reimbursements or grants available to the commonwealth, its
4072 departments, agencies, boards, divisions or political subdivisions for general health supplies, care
4073 and rehabilitative services and accommodations.

4074 In the event that any aggregate rates certified by the executive office exceed the upper
4075 limit of payment in effect for any period under Titles XVIII or Title XIX of the Social Security
4076 Act or any other requirement of said Titles, where applicable, the executive office shall re-
4077 determine and recertify any such aggregate rates in order to bring them into compliance with
4078 such federal requirement for the entire period during which such upper limit is effective.

4079 This section shall not apply to acute or non-acute hospitals; provided, however, that this
4080 section shall apply to acute and non-acute hospitals for services under the workers'
4081 compensation act.

4082 Section 13E. Except for rates established under section 13F, any person, corporation or
4083 other party aggrieved by an interim rate or a final rate established by the executive office or a
4084 governmental unit designated to perform ratemaking functions by the executive office, or by
4085 failure of the executive office to set a rate or to take other action required by law and desiring a
4086 review thereof shall, within 30 days after said rate is filed with the state secretary or may, at any
4087 time, if there is a failure to determine a rate or take any action required by law, file an appeal
4088 with the division of administrative law appeals established by section 4H of chapter 7. Any

4089 appeal filed under this section shall be accompanied by a certified statement that said appeal is
4090 not interposed for delay. On appeal, the rate determined for any provider of services shall be
4091 adequate, fair and reasonable for such provider, based upon, the costs of such provider, but not
4092 limited thereto.

4093 On an appeal from an interim rate or a final rate the division of administrative law
4094 appeals shall conduct an adjudicatory proceeding under chapter 30A, and said division shall file
4095 its decision with the secretary of the executive office and the state secretary within 30 days after
4096 the conclusion of the hearing.

4097 Said decision shall contain a statement of the reasons for such decision, including a
4098 determination of each issue of fact or law upon which such decision was based. If such decision
4099 results in a recommendation for a rate different from that certified, the executive office shall
4100 establish a new rate based upon such statement of reasons. If the secretary of the executive office
4101 determines that the statement of reasons is inadequate to determine a fair, reasonable and
4102 adequate rate, it may remand the appeal to the hearing officer for further investigation. Any party
4103 aggrieved by a decision of the division may, within 30 days of the receipt of such decision, file a
4104 petition for review in superior court for the county of Suffolk, which shall have exclusive
4105 jurisdiction of such review.

4106 A provider may appeal as an aggrieved party under the preceding sentence, in the event
4107 that a remand by the executive office to a hearing officer does not result in a final decision by the
4108 executive office within 21 days of the date of remand.

4109 The petition shall set forth the grounds upon which the decision of the division should be
4110 set aside. The aggrieved party shall, within 7 days after the petition for review is filed, notify the

4111 executive office and all the parties to the appeal before said division that a petition for review has
4112 been filed by sending each a copy thereof. Within 40 days after the petition for review is filed, or
4113 within such further time as the court may allow, the division of administrative law appeals shall
4114 file in court the original or a certified copy of the record under review. The court may affirm,
4115 modify or set aside the decision of the executive office in whole or in part, remand the decision
4116 to the executive office for further proceedings or enter such other order as justice may require.
4117 Nothing in this section shall be construed to prevent the division from granting temporary relief
4118 if, in its discretion, such relief is justified nor, from informally adjusting or settling controversies
4119 with the consent of all parties.

4120 Judicial review shall be governed by section 14 of chapter 30A to the extent not
4121 inconsistent with this section.

4122 Section 13E ½. All purchasers and third party payers, excluding purchasers and payers
4123 under the workers' compensation act, except as provided in chapter 152, may enter into
4124 contractual arrangements with acute and non-acute hospitals for services. No such arrangement,
4125 including, but not limited to, prices or charges which may be charged for non-contracted services
4126 or which may be negotiated in individual contracts between such purchasers or third party payers
4127 and such acute or non-acute hospitals, shall be subject to prior approval by any public agency;
4128 provided, however, that nothing in this chapter shall limit the authority of the executive office to
4129 establish rates of payment for all health care services adjudged compensable under chapter 152,
4130 and provided, further, that charges established by an acute or non-acute hospital for health care
4131 services rendered shall be uniform for all patients receiving comparable services.

4132 Any acute or non-acute hospital that makes a charge or accepts payment based upon a
4133 charge in excess of that filed, required or approved by the executive office or that fails to file any
4134 data, statistics or schedules or other information required under this chapter or by any regulation
4135 promulgated by the executive office or which falsifies the same, shall be subject to a civil
4136 penalty of not more than \$1,000 for each day on which such violation occurs or continues, which
4137 penalty may be assessed in an action brought on behalf of the commonwealth in any court of
4138 competent jurisdiction. The attorney general shall bring any appropriate action, including
4139 injunctive relief, as may be necessary for the enforcement of this chapter.

4140 Section 13F. All rates of payment to acute hospitals and non-acute hospitals under Title
4141 XIX shall be established by contract between the provider of such hospital services and the
4142 office of Medicaid, except as provided in subsections (a) and (b), or otherwise permitted by law.
4143 All rates shall be subject to all applicable Title XIX statutory and regulatory requirements and
4144 shall include reimbursement for the reasonable cost of providing competent interpreter services
4145 under section 25J of chapter 111 or section 23A of chapter 123.

4146 All such rates for non-acute hospitals shall be effective as of the date specified in section
4147 13A, unless otherwise specified by law.

4148 (a) For disproportionate share hospitals, the executive office shall establish rates that
4149 equal the financial requirements of providing care to recipients of medical assistance.

4150 (b) The executive office, or governmental unit designated by the executive office, shall
4151 establish rates of payment which shall apply to emergency services and continuing emergency
4152 care provided in acute hospitals to medical assistance program recipients, including examination
4153 or treatment for an emergency medical condition or active labor in women or any other care

4154 rendered to the extent required by 42 USC 1395(dd), unless such services are provided under an
4155 agreement between the office of Medicaid and the acute hospital. Such rates of payment shall
4156 reflect the reasonable costs of providing such care, including the costs of providing competent
4157 interpreter services under section 25J of chapter 111 or section 23A of chapter 123 and shall take
4158 into account the characteristics of the hospital in which such care is provided, including, but not
4159 limited to, its status as a teaching hospital, specialty hospital, disproportionate share hospital,
4160 pediatric hospital, pediatric specialty unit or sole community provider. An acute hospital shall,
4161 when a medical assistance program recipient requires post emergency room care and, after
4162 screening and stabilizing the patient's condition, notify the office of Medicaid or its designated
4163 representative and assist said office, to the extent possible, in transferring the recipient to an
4164 appropriate medical setting under said office's direction. Nothing in this section shall be
4165 construed to require the hospital to breach its obligation under said 42 USC 1395(dd) or require
4166 the recipient to forego any right to refuse transfer under said 42 USC 1395(dd). If an acute
4167 hospital is unable or prohibited by law or regulation from transferring the patient under said
4168 office's direction, said executive office shall pay for any and all care associated with such
4169 patient's treatment including, but not limited to, care or services provided in the emergency room
4170 or in an inpatient or outpatient setting. Whenever said office is required to pay for such care
4171 rendered in a non-emergency room setting, said office shall pay all reasonable costs for such
4172 services in such hospital, as determined by the executive office under this chapter and consistent
4173 with Title XIX laws.

4174 No acute hospital may charge to a governmental unit for services provided to publicly
4175 aided patients at a rate higher than the rate payable by the office of Medicaid under Title XIX for

4176 the same service, unless such service is provided by said office under a unique arrangement such
4177 as a selective contract or a managed care contract.

4178 Nothing in this chapter shall be construed to conflict with a waiver of otherwise
4179 applicable federal requirements which the office of Medicaid may obtain from the secretary of
4180 health and human services to implement a primary care case management system for delivering
4181 services, or to implement any other type of managed care service delivery system in which the
4182 eligible recipient is directed to obtain services exclusively from 1 provider or 1 group of
4183 providers.

4184 If the office of Medicaid, contracts with any third party payer for the provision of medical
4185 benefits for medical assistance recipients under Title XIX, said office shall assure that on a
4186 quarterly basis such contracted third party payers notify each acute hospital of the number of
4187 inpatient days of service provided by the hospital to such recipients covered by such contracts.

4188 (c) The executive office, or a governmental unit designated to perform ratemaking
4189 functions by the executive office, shall establish rates of payment which shall apply to
4190 community hospitals located in rural and isolated areas where access to other such providers is
4191 not reasonably available. Such hospitals, specially designated by the commonwealth as sole
4192 community providers, shall receive payment rates calculated to reflect the rural characteristics of
4193 such community hospital and the essential nature of the services provided, which rates shall not
4194 be less than 97 per cent of such hospitals' reasonable financial requirements.

4195 Section 13G. The executive office, or a governmental unit designated to perform
4196 ratemaking functions by the executive office, shall not consider the following as resources of
4197 such hospitals in the establishment, review or approval of acute and non-acute hospital rates and

4198 charges: restricted and unrestricted grants; gifts; contributions; bequests; fund principle; term
4199 endowments and endowment balances; restricted gifts; unrestricted gifts; and all income from
4200 any of the foregoing, including unrestricted income from endowment funds and income and
4201 gains from investment of unrestricted funds. The following words shall have the following
4202 meanings as used in this paragraph:

4203 “Income and gains from investment of unrestricted funds”, interest, dividends, rents or
4204 other income on investments, including net gains or losses resulting from investment
4205 transactions.

4206 “Term endowment”, funds available upon termination of restrictions.

4207 “Unrestricted gifts”, gifts, grants, contributions and bequests, upon which there are no
4208 restrictions imposed by the donor.

4209 “Unrestricted income from endowment funds”, income earned on investment of
4210 endowment funds which have no restrictions on income.

4211 An acute or non-acute care hospital aggrieved by any action or failure to act by the
4212 executive office under this chapter may file an appeal under section 13E.

4213 Section 13H. No acute hospital shall deny access to care and services which the hospital
4214 would provide under this chapter to recipients of benefits under chapter 117A.

4215 Section 13I. Notwithstanding any provisions of this chapter to the contrary, all costs and
4216 charges for patients who are residents of other countries shall, as provided herein, be exempted
4217 from the limitations imposed by this chapter. Any hospital shall be allowed to impose a
4218 surcharge on the normal charges that would otherwise be allowed for such residents of other

4219 countries. Such surcharges shall not be included in the calculation of gross patient service
4220 revenues. The normal charge and the patient discharge statistics shall otherwise be included
4221 under this chapter.

4222 Section 13J. A health maintenance organization organized under chapter 176G may; (i)
4223 negotiate directly with any hospital with respect to such health maintenance organization's rate
4224 of payment for hospital services; and (ii) enter into an agreement with such hospital reflecting
4225 such rate of payment without the approval of the executive office. The specification in this
4226 section of contracting rights of health maintenance organizations shall not be construed as
4227 affirming or denying such rights with respect to any other third party payer.

4228 Section 13K. Upon petition of a receiver appointed under section 72 N of chapter 111,
4229 the executive office shall, under regulations to be promulgated hereunder, adjust the facility's
4230 rate, if necessary, to insure compensation of the receiver and payment for a bond. Such
4231 adjustment shall not be in effect if the licensee is under the jurisdiction of the United States
4232 Bankruptcy Court.

4233 SECTION 124. Section 14 of said chapter 118E, as appearing in the 2010 Official
4234 Edition, is hereby amended by striking out, in lines 4 and 5 and 66, the words "division of health
4235 care finance and policy" and inserting in place thereof, in each instance, the following words:-
4236 executive office of health and human services or a governmental unit designated by the executive
4237 office.

4238 SECTION 125. Section 17A of said chapter 118E, as so appearing, is hereby amended by
4239 striking out, in lines 60 and 62, the word "physician" and inserting in place thereof, in each
4240 instance, the following word:- provider.

4241 SECTION 126. Subsection (e) of section 22 of said chapter 118E, as so appearing, is
4242 hereby amended by striking out, in lines 46 and 47, the words “36 of chapter 118G” and
4243 inserting in place thereof the following figure:- 66.

4244 SECTION 127. Subsection (k) of said section 22 of said chapter 118E, as so appearing, is
4245 hereby amended by striking out, in lines 93 and 96, the word “118G” and inserting in place
4246 thereof, in each instance, the following word:- 118E.

4247 SECTION 128. Said section 22 of said chapter 118E, as so appearing, is hereby further
4248 amended by striking out, in lines 44 and 45, 65, 71, 86 and 87 and 110, the words “division of
4249 health care finance and policy” and inserting in place thereof, in each instance, the following
4250 words:- executive office of health and human services.

4251 SECTION 129. Subsection (m) of said section 22 of said chapter 118E, as so appearing,
4252 is hereby amended by striking out, in lines 112 and 113, the words “39 of chapter 118G” and
4253 inserting in place thereof the following figure:- 69.

4254 SECTION 130. Section 23 of said chapter 118E, as so appearing, is hereby amended by
4255 striking out, in line 74, the words “39 of chapter 118G” and inserting in place thereof the
4256 following figure:- 69.

4257 SECTION 131. Said chapter 118E is hereby further amended by inserting after section 62
4258 the following 15 sections:—

4259 Section 63. (a) For the purposes of this section, the following words shall, unless the context
4260 clearly requires otherwise, have the following meanings:

4261 “Assessment”, the user fee imposed under this section; provided, that for all nursing
4262 homes, the user fee shall be imposed per non-Medicare reimbursed patient day; and provided,
4263 further that a Medicare-reimbursed patient day shall be a Medicare Part A patient day paid for
4264 under either an indemnity fee-for-service arrangement or a Medicare health maintenance
4265 organization contract.

4266 “Nursing home”, a nursing home or a distinct part of a nursing unit of a hospital or other
4267 facility licensed by the department of public health under section 71 of chapter 111.

4268 “Patient day”, a day of care provided to an individual patient by a nursing home.

4269 (b) Each nursing home shall pay an assessment per non-Medicare reimbursed patient day.
4270 The assessment shall be sufficient in the aggregate to generate \$145 million in each fiscal year.
4271 The assessment shall be implemented as a broad based health care-related fee as defined in 42
4272 U.S.C. § 1396b(w)(3)(B). The assessment shall be paid to the executive office quarterly. The
4273 executive office may promulgate regulations that authorize the assessment of interest on any
4274 unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees at a
4275 rate not to exceed 5 per cent per month. The receipts from the assessment, any federal financial
4276 participation received by the commonwealth as a result of expenditures funded by these
4277 assessments and interest thereon shall be credited to the General Fund.

4278 (c) The secretary of the executive office shall prepare a form on which each nursing
4279 home shall report quarterly its total patient days and shall calculate the assessment due. The
4280 secretary of the executive office shall distribute the forms to each nursing home at least annually.
4281 The failure to distribute the form or the failure to receive a copy of the form shall not stay the
4282 obligation to pay the assessment by the date specified in this section. The executive office may

4283 require additional reports, including but not limited to, monthly census data, as it considers
4284 necessary to monitor collections and compliance.

4285 (d) The executive office shall have the authority to inspect and copy the records of a
4286 nursing home to audit its calculation of the assessment. In the event that the executive office
4287 determines that a nursing home has either overpaid or underpaid the assessment, the executive
4288 office shall notify the nursing home of the amount due or refund the overpayment. The executive
4289 office may impose per diem penalties if a nursing home fails to produce documentation as
4290 requested by the executive office.

4291 (e) In the event that a nursing home is aggrieved by a decision of the executive office as
4292 to the amount due, the nursing home may file an appeal to the division of administrative law
4293 appeals within 60 days of the date of the notice of underpayment or the date the notice was
4294 received, whichever is later. The division of administrative law appeals shall conduct each
4295 appeal as an adjudicatory proceeding under chapter 30A and a nursing home aggrieved by a
4296 decision of the division of administrative law appeals shall be entitled to judicial review under
4297 section 14 of said chapter 30A.

4298 (f) The secretary of the executive office may enforce this section by notifying the
4299 department of public health of unpaid assessments. Within 45 days after notice to a nursing home
4300 of amounts due, the department shall revoke licensure of a nursing home that fails to remit
4301 delinquent fees.

4302 (g) The executive office, in consultation with the office of Medicaid, shall promulgate
4303 regulations necessary to implement this section.

4304 Section 64. As used in sections 64 to 69, inclusive, the following words shall, unless the
4305 context clearly requires otherwise, have the following meanings:

4306 “Acute hospital”, the teaching hospital of the University of Massachusetts medical school
4307 and any hospital licensed under section 51 of chapter 111 and which contains a majority of
4308 medical-surgical, pediatric, obstetric and maternity beds, as defined by the department of public
4309 health.

4310 "Allowable reimbursement", payment to acute hospitals and community health centers
4311 for health services provided to uninsured or underinsured patients of the commonwealth under
4312 section 69 and any further regulations promulgated by the health safety net office.

4313 "Ambulatory surgical center", a distinct entity that operates exclusively to provide
4314 surgical services to patients not requiring hospitalization and meets the requirements of the
4315 federal Health Care Financing Administration for participation in the Medicare program.

4316 "Ambulatory surgical center services", services described for purposes of the Medicare
4317 program under 42 U.S.C. 1395k(a)(2)(F)(I); provided that “ambulatory surgical center services”
4318 shall include facility services only and shall not include surgical procedures.

4319 "Bad debt", an account receivable based on services furnished to a patient which: (i) is
4320 regarded as uncollectible, following reasonable collection efforts consistent with regulations of
4321 the office, which regulations shall allow third party payers to negotiate with hospitals to collect
4322 the bad debts of its enrollees; (ii) is charged as a credit loss; (iii) is not the obligation of a
4323 governmental unit or the federal government or any agency thereof; and (iv) is not a
4324 reimbursable health care service.

4325 "Community health center", a health center operating in conformance with the
4326 requirements of Section 330 of United States Public Law 95-626, including all community health
4327 centers which file cost reports as requested by the center for health information and analysis.

4328 "Director", the director of the health safety net office.

4329 "DRG", a patient classification scheme known as diagnosis related grouping, which
4330 provides a means of relating the type of patients a hospital treats, such as its case mix, to the cost
4331 incurred by the hospital.

4332 "Emergency bad debt", bad debt resulting from emergency services provided by an acute
4333 hospital to an uninsured or underinsured patient or other individual who has an emergency
4334 medical condition that is regarded as uncollectible, following reasonable collection efforts
4335 consistent with regulations of the office.

4336 "Emergency medical condition", a medical condition, whether physical, behavioral,
4337 related to a substance use disorder or mental, manifesting itself by symptoms of sufficient
4338 severity, including severe pain, that the absence of prompt medical attention could reasonably be
4339 expected by a prudent layperson who possesses an average knowledge of health and medicine to
4340 result in placing the health of the person or another person in serious jeopardy, serious
4341 impairment to body function or serious dysfunction of any body organ or part or, with respect to
4342 a pregnant woman.

4343 "Emergency services", medically necessary health care services provided to an individual
4344 with an emergency medical condition.

4345 "Financial requirements", a hospital's requirement for revenue which shall include, but
4346 not be limited to, reasonable operating, capital and working capital costs, the reasonable costs of
4347 depreciation of plant and equipment and the reasonable costs associated with changes in medical
4348 practice and technology.

4349 "Fund", the Health Safety Net Trust Fund established under section 66.

4350 "Fund fiscal year", the 12-month period starting in October and ending in September.

4351 "Gross patient service revenue", the total dollar amount of a hospital's charges for
4352 services rendered in a fiscal year.

4353 "Health services", medically necessary inpatient and outpatient services as mandated
4354 under Title XIX of the federal Social Security Act; provided, that "health services" shall not
4355 include: (i) nonmedical services, such as social, educational and vocational services; (ii)
4356 cosmetic surgery; (iii) canceled or missed appointments; (iv) telephone conversations and
4357 consultations; (v) court testimony; (vi) research or the provision of experimental or unproven
4358 procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-
4359 surgery hormone therapy; and (vii) the provision of whole blood, but the administrative and
4360 processing costs associated with the provision of blood and its derivatives shall be payable.

4361 "Managed care organization", a managed care organization, as defined in 42 CFR 438.2,
4362 and any eligible health insurance plan, as defined in section 1 of chapter 118H, that contracts
4363 with MassHealth or the commonwealth health insurance connector authority; provided, however,
4364 that "managed care organization" shall not include a senior care organization, as defined in
4365 section 9D.

4366 "Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge
4367 payors to acute hospitals for health services and ambulatory surgical centers for ambulatory
4368 surgical center services; provided, however, that "payments subject to surcharge" shall not
4369 include: (i) payments, settlements and judgments arising out of third party liability claims for
4370 bodily injury which are paid under the terms of property or casualty insurance policies; and (ii)
4371 payments made on behalf of Medicaid recipients, Medicare beneficiaries or persons enrolled in
4372 policies issued under chapter 176K or similar policies issued on a group basis; provided further,
4373 that "payments subject to surcharge" shall include payments made by a managed care
4374 organization on behalf of: (1) Medicaid recipients under age 65; and (2) enrollees in the
4375 commonwealth care health insurance program; and provided further, that "payments subject to
4376 surcharge" may exclude amounts established under regulations promulgated by the division for
4377 which the costs and efficiency of billing a surcharge payor or enforcing collection of the
4378 surcharge from a surcharge payor would not be cost effective.

4379 "Pediatric hospital", an acute care hospital which limits services primarily to children and
4380 which qualifies as exempt from the Medicare Prospective Payment system regulations.

4381 "Pediatric specialty unit", a pediatric unit of an acute care hospital in which the ratio of
4382 licensed pediatric beds to total licensed hospital beds as of July 1, 1994 exceeded 0.20; provided
4383 that in calculating that ratio, licensed pediatric beds shall include the total of all pediatric service
4384 beds, and the total of all licensed hospital beds shall include the total of all licensed acute care
4385 hospital beds, consistent with Medicare's acute care hospital reimbursement methodology as put
4386 forth in the Provider Reimbursement Manual Part 1, Section 2405.3G.

4387 "Private sector charges", gross patient service revenue attributable to all patients less
4388 gross patient service revenue attributable to Titles XVIII and XIX, other public-aided patients,
4389 reimbursable health services and bad debt.

4390 "Reimbursable health services", health services provided to uninsured and underinsured
4391 patients who are determined to be financially unable to pay for their care, in whole or part, under
4392 applicable regulations of the office; provided that the health services are services provided by
4393 acute hospitals or services provided by community health centers; and provided further, that such
4394 services shall not be eligible for reimbursement by any other public or private third-party payer.

4395 "Resident", a person living in the commonwealth, as defined by the office by regulation;
4396 provided, however, that such regulation shall not define as a resident a person who moved into
4397 the commonwealth for the sole purpose of securing health insurance under this chapter.
4398 Confinement of a person in a nursing home, hospital or other medical institution shall not in and
4399 of itself, suffice to qualify such person as a resident.

4400 "Surcharge payor", an individual or entity that pays for or arranges for the purchase of
4401 health care services provided by acute hospitals and ambulatory surgical center services provided
4402 by ambulatory surgical centers, as defined in this section; provided, however, that the term
4403 "surcharge payor" shall include a managed care organization; and provided further, that
4404 "surcharge payor" shall not include Title XVIII and Title XIX programs and their beneficiaries or
4405 recipients, other governmental programs of public assistance and their beneficiaries or recipients
4406 and the workers' compensation program established under chapter 152.

4407 "Underinsured patient", a patient whose health insurance plan or self-insurance health
4408 plan does not pay, in whole or in part, for health services that are eligible for reimbursement

4409 from the health safety net trust fund, provided that such patient meets income eligibility
4410 standards set by the office.

4411 "Uninsured patient", a patient who is a resident of the commonwealth, who is not covered
4412 by a health insurance plan or a self-insurance health plan and who is not eligible for a medical
4413 assistance program.

4414 Section 65. (a) There shall be established within the office of Medicaid a health safety net
4415 office which shall be under the supervision and control of a director. The director shall be
4416 appointed by the secretary of the executive office and shall be a person of skill and experience in
4417 the field of health care finance and administration. The director shall be the executive and
4418 administrative head of the office and shall be responsible for administering and enforcing the law
4419 relative to the office and to each administrative unit of the office. The director shall receive such
4420 salary as may be determined by law, and shall devote full time to the duties of the office. In the
4421 case of an absence or vacancy in the office of the director, or in the case of disability as
4422 determined by the secretary of the executive office, the secretary of the executive office may
4423 designate an acting director to serve as director until the vacancy is filled or the absence or
4424 disability ceases. The acting director shall have all the powers and duties of the director and shall
4425 have similar qualifications as the director.

4426 (b) The office shall have the following powers and duties: (i) to administer the Health
4427 Safety Net Trust Fund, established under section 66, and to require payments to the fund
4428 consistent with acute hospitals' and surcharge payors' liability to the fund, as determined under
4429 sections 67 and 68, and any further regulations promulgated by the office; (ii) to set in
4430 consultation with the office of Medicaid, reimbursement rates for payments from the fund to

4431 acute hospitals and community health centers for reimbursable health services provided to
4432 uninsured and underinsured patients and to disburse monies from the fund consistent with such
4433 rates; provided that the office shall implement a fee-for-service reimbursement system for acute
4434 hospitals; (iii) to promulgate regulations further defining: (1) eligibility criteria for reimbursable
4435 health services; (2) the scope of health services that are eligible for reimbursement by the Health
4436 Safety Net Trust Fund; (3) standards for medical hardship; and (4) standards for reasonable
4437 efforts to collect payments for the costs of emergency care; provided that the office shall verify
4438 eligibility using the eligibility system of the office of Medicaid and other appropriate sources to
4439 determine the eligibility of uninsured and underinsured patients for reimbursable health services
4440 and shall establish other procedures to ensure that payments from the fund are made for health
4441 services for which there is no other public or private third party payer, including disallowance of
4442 payments to acute hospitals and community health centers for health services provided to
4443 individuals if reimbursement is available from other public or private sources; (iv) to develop
4444 programs and guidelines to encourage maximum enrollment of uninsured individuals who
4445 receive health services reimbursed by the fund into health care plans and programs of health
4446 insurance offered by public and private sources and to promote the delivery of care in the most
4447 appropriate setting, provided that the programs and guidelines are developed in consultation with
4448 the commonwealth health insurance connector, established under chapter 176Q; and provided
4449 further that these programs shall not deny payments from the fund because services should have
4450 been provided in a more appropriate setting if the hospital was required to provide the services
4451 under 42 U.S.C. 1395 dd; (v) to conduct a utilization review program designed to monitor the
4452 appropriateness of services for which payments were made by the fund and to promote the
4453 delivery of care in the most appropriate setting; and to administer demonstration programs that

4454 reduce health safety net trust fund liability to acute hospitals, including a demonstration program
4455 to enable disease management for patients with chronic diseases, substance abuse and psychiatric
4456 disorders through enrollment of patients in community health centers and community mental
4457 health centers and through coordination between these centers and acute hospitals, provided, that
4458 the office shall report the results of these reviews annually to the joint committee on health care
4459 financing and the house and senate committees on ways and means; (vi) to enter into agreements
4460 or transactions with any federal, state or municipal agency or other public institution or with a
4461 private individual, partnership, firm, corporation, association or other entity and to make
4462 contracts and execute all instruments necessary or convenient for the carrying on of its business;
4463 (vii) to secure payment, without imposing undue hardship upon any individual, for unpaid bills
4464 owed to acute hospitals by individuals for health services that are ineligible for reimbursement
4465 from the Health Safety Net Trust Fund which have been accounted for as bad debt by the
4466 hospital and which are voluntarily referred by a hospital to the department for collection;
4467 provided, however that such unpaid charges shall be considered debts owed to the
4468 commonwealth and all payments received shall be credited to the fund; and provided, further,
4469 that all actions to secure such payments shall be conducted in compliance with a protocol
4470 previously submitted by the office to the joint committee on health care financing; (viii) to
4471 require hospitals and community health centers to submit to the office data that it reasonably
4472 considers necessary; (ix) to make, amend and repeal rules and regulations to effectuate the
4473 efficient use of monies from the Health Safety Net Trust Fund; provided, however, that the
4474 regulations shall be promulgated only after notice and hearing and only upon consultation with
4475 the board of the commonwealth health insurance connector, representatives of the Massachusetts
4476 Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of

4477 Massachusetts Safety Net Hospitals, the Conference of Boston Teaching Hospitals and the
4478 Massachusetts League of Community Health Centers; and (x) to provide an annual report at the
4479 close of each fund fiscal year to the joint committee on health care financing and the house and
4480 senate committees on ways and means, evaluating the processes used to determine eligibility for
4481 reimbursable health services, including the Virtual Gateway. The report shall include, but not be
4482 limited to, the following: (1) an analysis of the effectiveness of these processes in enforcing
4483 eligibility requirements for publicly-funded health programs and in enrolling uninsured residents
4484 into programs of health insurance offered by public and private sources; (2) an assessment of the
4485 impact of these processes on the level of reimbursable health services by providers; and (3)
4486 recommendations for ongoing improvements that will enhance the performance of eligibility
4487 determination systems and reduce hospital administrative costs.

4488 Section 66. (a) There shall be established and set up on the books of the commonwealth
4489 a fund to be known as the Health Safety Net Trust Fund, in this section and in sections 67 to 69,
4490 inclusive, called the fund, which shall be administered by the office. Expenditures from the fund
4491 shall not be subject to appropriation unless otherwise required by law. The purposes of the fund
4492 shall be: (i) to maintain a health care safety net by reimbursing hospitals and community health
4493 centers for a portion of the cost of reimbursable health services provided to low-income,
4494 uninsured or underinsured residents; and (ii) to support a portion of the costs of the Medicaid
4495 program this chapter and the commonwealth care health insurance program under chapter 118H.
4496 The office shall administer the fund using such methods, policies, procedures, standards and
4497 criteria that it deems necessary for the proper and efficient operation of the fund and programs
4498 funded by it in a manner designed to distribute the fund resources as equitably as possible. The

4499 director of the health safety net office shall determine annually the estimated expenses of the
4500 office to administer the fund.

4501 (b) The fund shall consist of all amounts paid by acute hospitals and surcharge payors
4502 under sections 67 and 68; all appropriations for the purpose of payments to acute hospitals or
4503 community health centers for health services provided to uninsured and underinsured residents;
4504 any transfers from the Commonwealth Care Trust Fund, established under section 2000 of
4505 chapter 29; and all property and securities acquired by and through the use of monies belonging
4506 to the fund and all interest thereon. Amounts placed in the fund shall, except for amounts
4507 transferred to the Commonwealth Care Trust Fund, be expended by the office for payments to
4508 hospitals and community health centers for reimbursable health services provided to uninsured
4509 and underinsured residents of the commonwealth, consistent with the requirements of this
4510 section and section 69 and the regulations promulgated by the office; provided, however, that
4511 expenses of the health safety net office under subsection (a) shall be expended annually from the
4512 fund; and provided further, that not more than \$6,000,000 shall be expended annually from the
4513 fund for demonstration projects that use case management and other methods to reduce the
4514 liability of the fund to acute hospitals; and provided further, that any amounts collected from
4515 surcharge payors in any year in excess of \$160,000,000, adjusted to reflect applicable surcharge
4516 credits, shall be transferred to the General Fund to support a portion of the costs of the Medicaid
4517 and commonwealth care health insurance programs. Any annual balance remaining in the fund
4518 after these payments have been made shall be transferred to the Commonwealth Care Trust
4519 Fund. All interest earned on the amounts in the fund shall be deposited or retained in the fund.
4520 The director shall from time to time requisition from the fund amounts that the director considers

4521 necessary to meet the current obligations of the office for the purposes of the fund and estimated
4522 obligations for a reasonable future period.

4523 Section 67. (a) An acute hospital's liability to the fund shall equal the product of: (i) the
4524 ratio of its private sector charges to all acute hospitals' private sector charges; and (ii)
4525 \$160,000,000. Annually, before October 1, the office shall establish each acute hospital's
4526 liability to the fund using the best data available, as determined by the health safety net office
4527 and shall update each acute hospital's liability to the fund as updated information becomes
4528 available. The office shall specify by regulation an appropriate mechanism for interim
4529 determination and payment of an acute hospital's liability to the fund. An acute hospital's
4530 liability to the fund shall in the case of a transfer of ownership be assumed by the successor in
4531 interest to the acute hospital.

4532 (b) The office shall establish by regulation an appropriate mechanism for enforcing an
4533 acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled
4534 payment to the fund. These enforcement mechanisms may include: (i) an offset by the office of
4535 Medicaid of payments on the Title XIX claims of any such acute hospital or any health care
4536 provider under common ownership with the acute care hospital or any successor in interest to the
4537 acute hospital; and (ii) the withholding by the office of Medicaid of the amount of payment owed
4538 to the fund, including any interest and late fees and the transfer of the withheld funds into the
4539 fund. If the office of Medicaid offsets claims payments as ordered by the office, it shall not be
4540 considered to be in breach of contract or any other obligation for the payment of non-contracted
4541 services and providers whose payment is offset under an order of the division shall serve all Title
4542 XIX recipients under the contract then in effect with the office of Medicaid, or, in the case of a
4543 non-contracting or disproportionate share hospital, under its obligation for providing services to

4544 Title XIX recipients under this chapter. In no event shall the office direct the office of Medicaid
4545 to offset claims unless an acute hospital has maintained an outstanding obligation to the fund for
4546 a period longer than 45 days and has received proper notice that the office of Medicaid intends to
4547 initiate enforcement actions under regulations promulgated by the office.

4548 Section 68. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge
4549 on all payments subject to surcharge as defined in section 64. The surcharge shall be distinct
4550 from any other amount paid by a surcharge payor for the services of an acute hospital or
4551 ambulatory surgical center. The surcharge amount shall equal the product of: (i) the surcharge
4552 percentage; and (ii) amounts paid for these services by a surcharge payor. The office shall
4553 calculate the surcharge percentage by dividing \$160,000,000 by the projected annual aggregate
4554 payments subject to the surcharge, excluding projected annual aggregate payments based on
4555 payments made by managed care organizations. The office shall determine the surcharge
4556 percentage before the start of each fund fiscal year and may re-determine the surcharge
4557 percentage before April 1 of each fund fiscal year if the office projects that the initial surcharge
4558 percentage established the previous October will produce less than \$150,000,000 or more than
4559 \$170,000,000 in surcharge payments, excluding payments made by managed care organizations.
4560 Before each succeeding October 1, the office shall re-determine the surcharge percentage
4561 incorporating any adjustments from earlier years. In each determination or redetermination of the
4562 surcharge percentage, the office shall use the best data available as determined by the office of
4563 Medicaid and may consider the effect on projected surcharge payments of any modified or
4564 waived enforcement under subsection (e). The office shall incorporate all adjustments, including,
4565 but not limited to, updates or corrections or final settlement amounts, by prospective adjustment
4566 rather than by retrospective payments or assessments.

4567 (b) Each acute hospital and ambulatory surgical center shall bill a surcharge payor an
4568 amount equal to the surcharge described in subsection (a) as a separate and identifiable amount
4569 distinct from any amount paid by a surcharge payor for acute hospital or ambulatory surgical
4570 center services. Each surcharge payor shall pay the surcharge amount to the office for deposit in
4571 the Health Safety Net Trust Fund on behalf of said acute hospital or ambulatory surgical center.
4572 Upon the written request of a surcharge payor, the office may implement another billing or
4573 collection method for the surcharge payor; provided, however, that the office has received all
4574 information that it requests which is necessary to implement such billing or collection method;
4575 and provided further, that the office shall specify by regulation the criteria for reviewing and
4576 approving such requests and the elements of such alternative method or methods.

4577 (c) The office shall specify by regulation appropriate mechanisms that provide for
4578 determination and payment of a surcharge payor's liability, including requirements for data to be
4579 submitted by surcharge payors, acute hospitals and ambulatory surgical centers.

4580 (d) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
4581 assumed by the successor in interest to the surcharge payor.

4582 (e) The office shall establish by regulation an appropriate mechanism for enforcing a
4583 surcharge payor's liability to the fund if a surcharge payor does not make a scheduled payment to
4584 the fund; provided, however, that the office may, for the purpose of administrative simplicity,
4585 establish threshold liability amounts below which enforcement may be modified or waived. Such
4586 enforcement mechanism may include assessment of interest on the unpaid liability at a rate not to
4587 exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5
4588 per cent per month. Such enforcement mechanism may also include notification to the office of

4589 Medicaid requiring an offset of payments on the claims of the surcharge payor, any entity under
4590 common ownership or any successor in interest to the surcharge payor, from the office of
4591 Medicaid in the amount of payment owed to the fund including any interest and penalties, and to
4592 transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as
4593 ordered by the office, the office of Medicaid shall be considered not to be in breach of contract
4594 or any other obligation for payment of non-contracted services, and a surcharge payor whose
4595 payment is offset under an order of the office shall serve all Title XIX recipients under the
4596 contract then in effect with the executive office of health and human services. In no event shall
4597 the office direct the office of Medicaid to offset claims unless the surcharge payor has
4598 maintained an outstanding liability to the fund for a period longer than 45 days and has received
4599 proper notice that the office intends to initiate enforcement actions under regulations
4600 promulgated by the office.

4601 (f) If a surcharge payor fails to file any data, statistics or schedules or other information
4602 required under this chapter or by any regulation promulgated by the office, the office shall
4603 provide written notice to the payor. If a surcharge payor fails to provide required information
4604 within 14 days after the receipt of written notice, or falsifies the same, the surcharge payor shall
4605 be subject to a civil penalty of not more than \$5,000 for each day on which the violation occurs
4606 or continues, which penalty may be assessed in an action brought on behalf of the
4607 commonwealth in any court of competent jurisdiction. The attorney general shall bring any
4608 appropriate action, including injunctive relief, necessary for the enforcement of this chapter.

4609 Section 69. (a) Reimbursements from the fund to hospitals and community health centers
4610 for health services provided to uninsured and underinsured individuals shall be subject to further
4611 rules and regulations promulgated by the office and shall be made in the following manner:-

4612 (1) Reimbursements made to acute hospitals shall be based on actual claims for
4613 health services provided to uninsured and underinsured patients that are submitted to the office,
4614 and shall be made only after determination that the claim is eligible for reimbursement under this
4615 chapter and any additional regulations promulgated by the office. Reimbursements for health
4616 services provided to residents of other states and foreign countries shall be prohibited and the
4617 office shall make payments to acute hospitals using fee-for-service rates calculated as provided
4618 in paragraphs (5) and (6).

4619 (2) The office shall, in consultation with the office of Medicaid, develop and
4620 implement procedures to verify the eligibility of individuals for whom health services are billed
4621 to the fund and to ensure that other coverage options are used fully before services are billed to
4622 the fund, including procedures adopted under section 66. The office may recover from a third
4623 party that is financially responsible for the costs attributable to services provided to an individual
4624 that were paid by the fund. A payment from the fund for such services shall be recoverable from
4625 the third party and the payment shall, after notice to the third party, operate as a lien under
4626 section 22 . The office shall review all claims billed to the fund to determine whether the patient
4627 is eligible for medical assistance under this chapter and whether any third party is financially
4628 responsible for the costs of care provided to the patient. In making these determinations, the
4629 office shall verify the insurance status of each individual for whom a claim is made using all
4630 sources of data available to the office. The office shall refuse to allow payments or shall disallow
4631 payments to acute hospitals and community health centers for free care provided to individuals if
4632 reimbursement is available from other public or private sources; provided, that payments shall
4633 not be denied from the fund because services should have been provided in a more appropriate
4634 setting if the hospital was required to provide these services under 42 U.S.C. 1395(dd).

4635 (3) The office shall require acute hospitals and community health centers to
4636 screen each applicant for reimbursed care for other sources of coverage and for potential
4637 eligibility for government programs and to document the results of that screening. If an acute
4638 hospital or community health center determines that an applicant is potentially eligible for
4639 Medicaid or for the commonwealth care health insurance program, established under chapter
4640 118H, or another assistance program, the acute hospital or community health center shall assist
4641 the applicant in applying for benefits under that program. The office shall audit the accounts of
4642 acute hospitals and community health centers to determine compliance with this section and shall
4643 deny payments from the fund for any acute hospital or community health center that fails to
4644 document compliance with this section.

4645 (4) Notwithstanding any general or special law to the contrary, an applicant for
4646 health safety net assistance shall, if eligible, be enrolled in MassHealth under section 9A or in the
4647 insurance reimbursement program, as provided in section 9C. An applicant deemed ineligible
4648 for either program and who is unable to make all or part of the payment for health services shall
4649 provide the name and address of the applicant's employer, if any, and the applicant's name,
4650 address, social security number and date of birth. The director of labor, in collaboration with the
4651 office, shall collaborate with the division of insurance and the department of revenue to
4652 implement this section and section 17 of chapter 176Q.

4653 (5) To pay community health centers for health services provided to uninsured
4654 individuals under this section, the office shall pay community health centers a base rate that shall
4655 be no less than the then-current Medicare Federally Qualified Health Center rate, and the office
4656 shall add payments for additional services not included in the base rate, including, but not limited
4657 to, EPSDT services, 340B pharmacy, urgent care and emergency room diversion services.

4658 (6) Reimbursements to acute hospitals and community health centers for bad debt
4659 shall be made upon submission of evidence, in a form to be determined by the office, that
4660 reasonable efforts to collect the debt have been made.

4661 (7) The office shall reimburse acute hospitals for health services provided to
4662 individuals based on the payment systems in effect for acute hospitals used by the United States
4663 Department of Health and Human Services Centers for Medicare & Medicaid Services to
4664 administer the Medicare Program under Title XVIII of the Social Security Act, including all of
4665 Medicare's adjustments for direct and indirect graduate medical education, disproportionate
4666 share, outliers, organ acquisition, bad debt, new technology and capital and the full amount of
4667 the annual increase in the Medicare hospital market basket index. The office shall, in
4668 consultation with the office of Medicaid and the Massachusetts Hospital Association, promulgate
4669 regulations necessary to modify these payment systems to account for: (i) the differences
4670 between the program administered by the office and the Title XVIII Medicare program,
4671 including the services and benefits covered; (ii) grouper and DRG relative weights for purposes
4672 of calculating the payment rates to reimburse acute hospitals at rates not less than the rates they
4673 are reimbursed by Medicare; (iii) the extent and duration of covered services; (iv) the
4674 populations served; and (v) any other adjustments to the payment methodology under this section
4675 as considered necessary by the office, based upon circumstances of individual hospitals.

4676 Following implementation of this section, the office shall ensure that the allowable
4677 reimbursement rates under this section for health services provided to uninsured individuals shall
4678 not thereafter be less than rates of payment for comparable services under the Medicare program,
4679 taking into account the adjustments required by this section.

4680 (b) By April 1 of the year preceding the start of the fund fiscal year, the office shall, after
4681 consultation with the office of Medicaid, and using the best data available, provide an estimate of
4682 the projected total reimbursable health services provided by acute hospitals and community
4683 health centers and emergency bad debt costs, the total funding available and any projected
4684 shortfall after adjusting for reimbursement payments to community health centers. If a shortfall
4685 in revenue exists in any fund fiscal year to cover projected costs for reimbursement of health
4686 services, the office shall allocate that shortfall in a manner that reflects each hospital's
4687 proportional financial requirement for reimbursements from the fund, including, but not limited
4688 to, the establishment of a graduated reimbursement system and under any additional regulations
4689 promulgated by the office.

4690 (c) The executive office of health and human services shall enter into interagency
4691 agreements with the department of revenue to verify income data for patients whose health care
4692 services are reimbursed by the Health Safety Net Trust Fund and to recover payments made by
4693 the fund for services provided to individuals who are ineligible to receive reimbursable health
4694 services or on whose behalf the fund has paid for emergency bad debt. The office shall
4695 promulgate regulations requiring acute hospitals to submit data to enable the department of
4696 revenue to pursue recoveries from individuals who are ineligible for reimbursable health services
4697 and on whose behalf the fund has made payments to acute hospitals for such services or
4698 emergency bad debt. Any amounts recovered, including amounts received under chapter 62D,
4699 shall be deposited in the Health Safety Net Trust Fund, established in section 66.

4700 (d) The office shall not at any time make payments from the fund for any period in excess
4701 of amounts that have been paid into or are available in the fund for that period, but the office
4702 may temporarily prorate payments from the fund for cash flow purposes.

4703 Section 70. As used in sections 70 to 75 inclusive, the following words shall, unless the
4704 context requires otherwise, have the following meanings:—

4705 “Consumer,” a person to whom a personal care attendant provides personal care services.

4706 “PCA quality home care workforce council”, “workforce council” or “the council”, the
4707 Personal Care Attendant quality home care workforce council established in section 71.

4708 “Personal care attendant,” a person, including a personal aide, who has been selected by a
4709 consumer or the consumer’s surrogate to provide personal care services to persons with
4710 disabilities or seniors under the MassHealth personal care attendant program or any successor
4711 program.

4712 “Surrogate”, a consumer’s legal guardian or person identified in a written agreement with
4713 the consumer as responsible for hiring, directing and firing on behalf of the consumer.

4714 Section 71. (a) There shall be a PCA quality home care workforce council which shall be
4715 within the executive office of health and human services but shall not be subject to the control of
4716 the executive office, to ensure the quality of long-term, in-home, personal care by recruiting,
4717 training and stabilizing the work force of personal care attendants.

4718 (b) The PCA quality home care workforce council shall consist of 9 members appointed
4719 under this section. A majority of the members of the council shall be consumers as defined in
4720 this chapter. In making appointments to the council, the governor shall appoint the secretary of
4721 the executive office of health and human services or a designee, who shall serve as chair, the
4722 secretary of labor and workforce development or a designee and 1 member from a slate of 3
4723 consumers recommended by the governor's special advisory commission on disability policy.

4724 The auditor shall appoint 1 member from a slate of 3 consumers recommended by the
4725 developmental disabilities council, 1 member from a slate of 3 consumers recommended by the
4726 Massachusetts office on disability, and 1 member from a slate of 3 consumers recommended by
4727 the statewide independent living council. The attorney general shall appoint 1 member from a
4728 slate of 3 consumers or consumer surrogates recommended by the Massachusetts home care
4729 association, 1 member from a slate of 3 consumers or consumer surrogates recommended by the
4730 Massachusetts council on aging and 1 member chosen by the attorney general. The secretary of
4731 health and human services or a designee and the secretary of labor and workforce development
4732 or a designee shall be permanent members during their term in office. Appointees to the council
4733 shall serve 3-year terms. If a vacancy occurs, the executive officer who made the original
4734 appointment shall appoint a new council member to serve the remainder of the unexpired term
4735 or, in the event that the vacancy occurs as the result of the completion of a term, to serve a full
4736 term, and such appointment shall become immediately effective upon the member taking the
4737 appropriate oath. If the departing council member was appointed under a recommendation made
4738 under this paragraph, the executive officer shall make the new appointment from a slate of 3
4739 recommendations put forth by the entity that originally recommended the departing council
4740 member. Members of the council may serve for successive terms of office. A majority of the
4741 council shall constitute a quorum for the transaction of any business. Members of the council
4742 shall not receive compensation for their council service but members shall be reimbursed for
4743 their actual expenses necessarily incurred in the performance of their duties.

4744 Section 72. (a) The workforce council shall carry out the following duties:

4745 (1) Undertake recruiting efforts to identify and recruit prospective personal care
4746 attendants;

4747 (2) Provide training opportunities, either directly or through contract, for personal
4748 care attendants and consumers;

4749 (3) Provide assistance to consumers and consumer surrogates in finding personal
4750 care attendants by establishing a referral directory of personal care attendants; provided that
4751 before placing a personal care attendant on the referral directory, the workforce council shall
4752 determine that the personal care attendant has met the requirements established by the executive
4753 office in its applicable regulations and has not stated in writing a desire to be excluded from the
4754 directory;

4755 (4) Provide routine, emergency and respite referrals of personal care attendants to
4756 consumers and consumer surrogates who are authorized to receive long-term, in-home personal
4757 care services through a personal care attendant;

4758 (5) Give preference in the recruiting, training, referral and employment of
4759 personal care attendants to recipients of public assistance or other low-income persons who
4760 would qualify for public assistance in the absence of such employment; and

4761 (6) Cooperate with state and local agencies on health and aging and other federal,
4762 state and local agencies to provide the services described and set forth in this section. If the PCA
4763 quality home care workforce council identifies concerns regarding the services being provided
4764 by a personal care attendant, the workforce council shall notify the relevant office.

4765 (b) In determining how best to carry out its duties, the PCA quality home care workforce
4766 council shall identify existing personal care attendant recruitment, training and referral resources
4767 made available to consumers or the consumer's surrogate by other state and local public, private
4768 and nonprofit agencies. The council may coordinate with the agencies to provide a local presence

4769 for the council and to provide consumers or the consumer's surrogate greater access to personal
4770 care attendant recruitment, training and referral resources in a cost-effective manner. Using
4771 requests for proposals or similar processes, the council may contract with the agencies to provide
4772 recruitment, training and referral. The council shall provide an opportunity for consumer
4773 participation in coordination efforts.

4774 (c) The commonwealth shall provide to the council a list of all personal care attendants
4775 who have been paid through the MassHealth personal care attendant program and shall update
4776 the list not less frequently than every 6 months to ensure that the council has a complete and
4777 accurate list at all times.

4778 Section 73. (a) Consumers or the consumer's surrogate shall retain the right to select,
4779 hire, schedule, train, direct, supervise and terminate any personal care attendant providing
4780 services to the consumer or consumer's surrogate. Consumers or the consumer's surrogate may
4781 elect to receive long-term, in-home personal care services from personal care attendants who are
4782 not referred to the consumer or consumer's surrogate by the council.

4783 (b) Personal care attendants shall be considered public employees, as defined by and
4784 solely for the purposes of, chapter 150E and section 17J of chapter 180. Said chapter 150E shall
4785 apply to personal care attendants except to the extent that chapter 150E is inconsistent with this
4786 section, in which case this section shall control. In addition, personal care attendants shall be
4787 treated as state employees solely for the purposes of sections 17A and 17G of chapter 180.
4788 Personal care attendants shall not be considered public employees or state employees for any
4789 purpose other than those set forth in this paragraph. The PCA quality home care workforce
4790 council shall be the employer, as defined by and solely for the purposes of said chapter 150E and

4791 said sections 17A, 17G and 17J of said chapter 180 and deductions under said sections 17A, 17G
4792 and 17J may be made by any entity authorized by the commonwealth to compensate personal
4793 care attendants through the MassHealth personal care attendant program. Personal care
4794 attendants shall not be eligible for benefits through the group insurance commission, the state
4795 board of retirement or the state employee workers' compensation program.

4796 (c) Personal care attendants who are employees of the council under this section shall not
4797 be considered, for that reason, public employees or employees of the council for any other
4798 purpose. Nothing in this chapter shall alter the obligations of the commonwealth or the consumer
4799 to provide their share of social security, federal and state unemployment taxes, Medicare and
4800 worker's compensation insurance under the Federal Insurance Contributions Act, federal and
4801 state unemployment law or the Massachusetts Workers' Compensation Act.

4802 (d) Consistent with section 9A of chapter 150E, no personal care attendant shall engage
4803 in a strike and no personal care attendant shall induce, encourage or condone any strike, work
4804 stoppage, slowdown or withholding of services by any personal care attendant.

4805 (e) The only bargaining unit appropriate for the purpose of collective bargaining shall be
4806 a statewide unit of all personal care attendants. The showing of interest required to request an
4807 election is 10 per cent of the bargaining unit. An intervener seeking to appear on the ballot must
4808 make the same showing of interest.

4809 (f) The council or its contractors, may not be held vicariously liable for the action or
4810 inaction of any personal care attendant, whether or not that personal care attendant was included
4811 on the council's referral directory or referred to a consumer or the consumer's surrogate.

4812 (g) The members of the council shall be immune from any liability resulting from
4813 implementation of sections 70 to 75, inclusive.

4814 Section 74. (a) The PCA quality home care workforce council may make and execute
4815 contracts and all other instruments necessary or convenient for the performance of its duties or
4816 exercise of its powers, including contracts with public and private agencies, organizations,
4817 corporations and individuals to pay them for services rendered or furnished.

4818 (b) The council may offer and provide recruitment, training and referral services to
4819 personal care attendants and consumers of long-term, in-home personal care services other than
4820 statutorily defined personal care attendants and consumers, for a fee to be determined by the
4821 council.

4822 (c) The council may issue rules or regulations, as necessary, for the purpose and policies
4823 of sections 70 to 75, inclusive.

4824 (d) Subject to appropriation, the chairperson of the council with the council's approval
4825 may establish offices, employ and discharge employees, agents and contractors as necessary and
4826 prescribe employees' duties and powers and fix the employees' compensation, incur expenses,
4827 and create such liabilities as are reasonable and proper for the administration of sections 70 to
4828 75, inclusive.

4829 (e) The council may solicit and accept for use any grant of money, services or property
4830 from the federal government, the state or any political subdivision or agency thereof, including
4831 federal matching funds under Title XIX of the federal Social Security Act, and do all things
4832 necessary to cooperate with the federal government, the state, or any political subdivision or
4833 agency thereof, in making an application for any grant.

4834 (f) The council may coordinate its activities and cooperate with similar agencies in other
4835 states.

4836 (g) The council may establish technical advisory committees to assist the council.

4837 (h) The council may keep records and engage in research and the gathering of relevant
4838 statistics.

4839 (i) The council may acquire, hold or dispose of real or personal property, or any interest
4840 therein, and construct, lease or otherwise provide facilities for the activities conducted under
4841 sections 70 to 75, inclusive, but the workforce council may not exercise any power of eminent
4842 domain.

4843 (j) The council may delegate to the appropriate persons the power to execute contracts
4844 and other instruments on its behalf and delegate any of its powers and duties, if consistent with
4845 sections 70 to 75, inclusive.

4846 (k) The council may perform other acts necessary or convenient to execute the powers
4847 expressly granted to it.

4848 Section 75. (a) The council shall conduct a performance review every 2 years, submit a
4849 report of the review to the legislature and the governor and make the report available to the
4850 public upon submission to the governor and the legislature.

4851 (b) The performance review and report shall include an evaluation of the health, welfare
4852 and satisfaction with services provided of the consumers receiving long-term in-home personal
4853 care services from personal care attendants under sections 70 to 75, inclusive, including the
4854 degree to which all required services have been delivered, the degree to which consumers

4855 receiving services from personal care attendants have ultimately required additional or more
4856 intensive services, such as home health care, or have been placed in other residential settings or
4857 nursing homes, the promptness of response to consumer complaints and any other issue
4858 considered to be relevant.

4859 (c) The performance review report shall provide an explanation of the full cost of
4860 personal care services, including the administrative costs of the council, unemployment
4861 compensation, Social Security and Medicare payroll taxes paid and any oversight costs.

4862 (d) The performance review report shall make recommendations to the legislature and the
4863 governor for any amendments to sections 70 to 75, inclusive to further ensure the well-being of
4864 consumers, and the most efficient means of delivering required services.

4865 Section 76. The secretary of the executive office may designate another governmental
4866 unit or units to perform any or all functions set forth in sections 13C to 13K, inclusive, and
4867 sections 64 to 75, inclusive. Such designee specifically may include the center for health
4868 information and analysis established under chapter 12C of the General Laws. The secretary may
4869 effectuate such designation through a memorandum of understanding, nonfinancial
4870 interdepartmental service agreement or similar instrument, and such designee shall be a party to
4871 any such instrument and perform the activities described therein.

4872 Section 77. To the maximum extent possible, the office of Medicaid shall attribute every
4873 member to a primary care provider. Members may change their primary care provider, provided
4874 that the member gives notice to the office of Medicaid.

4875 SECTION 132. Chapter 118G of the General Laws is hereby repealed.

4876 SECTION 133. Chapter 118H of the General Laws is hereby amended by adding the
4877 following section:-

4878 Section 7. To the maximum extent possible, the commonwealth care health insurance
4879 program shall attribute every member to a primary care provider. Members may change primary
4880 care providers, provided that the member gives notice to the commonwealth care health
4881 insurance program.

4882 SECTION 134. The General Laws are hereby amended by inserting after chapter 118H
4883 the following chapter:—

4884 CHAPTER 118I.

4885 HEALTH INFORMATION TECHNOLOGY

4886 Section 1. As used in this chapter, the following words shall, unless the context clearly
4887 requires otherwise, have the following meanings:

4888 “Commission”, the health policy commission established in section 2 of chapter 6D.

4889 “Council”, the health information technology council established under section 2.

4890 “Electronic health record,” an electronic record of patient health information generated
4891 by 11 or more encounters in any care delivery setting.

4892 “Executive office”, the executive office of health and human services.

4893 “Health information exchange,” an electronic platform enabling the transmission of
4894 healthcare-related data among providers, payers, personal health records controlled by a patient

4895 and government agencies according to national standards, the reliable and secure transfer of data
4896 among diverse systems and access to and retrieval of data.

4897 “Longitudinal medical record”, a patient’s lifetime electronic health record whether
4898 located, maintained or stored on a provider server, at a central storage repository, or distributed
4899 in multiple locations but accessible with patient consent.

4900 “Massachusetts eHealth institute” or “institute”, the Massachusetts e-Health institute
4901 established under section 6D of chapter 40J.

4902 “Office of the National Coordinator” or “ONC”, the Office of the National Coordinator
4903 for Health Information Technology within the United States Department of Health and Human
4904 Services.

4905 “Statewide health information exchange”, a health information exchange established,
4906 operated or funded by a governmental entity or entities in the commonwealth.

4907 Section 2. (a) There shall be a health information technology council within the executive office
4908 of health and human services. The council shall coordinate with state agencies, including the
4909 commission, other governmental entities and private stakeholders to develop a statewide health
4910 information exchange. The council shall advise the executive office on design, implementation,
4911 operation and use of the statewide health information exchange and related infrastructure.

4912 (b) The council shall consist of the following 21 members: the secretary of health and
4913 human services or a designee, who shall serve as the chair; the secretary of administration and
4914 finance or a designee; the executive director of the health policy commission or a designee; the
4915 executive director of the center for health information analysis; the director of the Massachusetts

4916 e-Health Institute; the secretary of housing and economic development or a designee; the director
4917 of the office of Medicaid or a designee; and 14 members who shall be appointed by the governor,
4918 of whom at least 1 shall be an expert in health information technology; 1 shall be an expert in
4919 law and health policy; 1 shall be an expert in health information privacy and security; 1 shall be
4920 from an academic medical center; 1 shall be from a community hospital; 1 shall be from a
4921 community health center; 1 shall be from a long term care facility; 1 shall be a from large
4922 physician group practice; 1 shall be from a small physician group practice; 1 shall be a registered
4923 nurse; 1 shall be from a behavioral health, substance abuse disorder or mental health services
4924 organization; 1 shall represent health insurance carriers; and 2 additional members shall have
4925 experience or expertise in health information technology. The council may consult with all
4926 relevant parties, public or private, in exercising its duties under this section, including persons
4927 with expertise and experience in the development and dissemination of electronic health records
4928 systems, and the implementation of electronic health record systems by small physician groups
4929 or ambulatory care providers, as well as persons representing organizations within the
4930 commonwealth interested in and affected by the development of networks and electronic health
4931 records systems, including, but not limited to, persons representing local public health agencies,
4932 licensed hospitals and other licensed facilities and providers, private purchasers, the medical and
4933 nursing professions, physicians and health insurers, the state quality improvement organization,
4934 academic and research institutions, consumer advisory organizations with expertise in health
4935 information technology and other stakeholders as identified by the secretary of health and human
4936 services. Appointed members of the council shall serve for terms of 2 years or until a successor
4937 is appointed. Members shall be eligible to be reappointed and shall serve without compensation.

4938 Chapter 268A shall apply to all council members, except that the council may purchase
4939 from, sell to, borrow from, contract with or otherwise deal with any organization in which any
4940 council member is in anyway interested or involved; provided, however, that such interest or
4941 involvement shall be disclosed in advance to the council and recorded in the minutes of the
4942 proceedings of the council; and provided, further, that no member shall be considered to have
4943 violated section 4 of said chapter 268A because of the member's receipt of usual and regular
4944 compensation from such member's employer during the time in which the member participates
4945 in the activities of the council.

4946 Section 3. (a) The executive office shall conduct procurements and enter into contracts
4947 for the purchase and development of all hardware and software in connection with the creation
4948 and implementation of the statewide health information exchange. The executive office may, in
4949 consultation with the council and the commission, oversee the technical aspects of the
4950 development, dissemination and implementation of the statewide health information exchange
4951 including any modules, applications, interfaces or other technology infrastructure necessary to
4952 connect provider electronic health records systems to the statewide health information exchange.

4953 (b) The executive office shall:

4954 (i) in consultation with the council, develop a health information exchange strategic and
4955 operating plan;

4956 (ii) implement, operate and maintain the statewide health information exchange;

4957 (iii) develop and implement statewide health information exchange infrastructure,
4958 including, without limitation, provider directories, certificate storage, transmission gateways,

4959 auditing systems and any components necessary to connect the statewide health information
4960 exchange to provider electronic health records systems; and

4961 (iv) take all actions necessary to directly manage the Office of the National Coordinator-
4962 HIE Cooperative Agreement and ONC Challenge Grant programs, including the termination of
4963 the current State Designated Entity delegation and the transfer of management responsibility of
4964 said ONC-HIE Cooperative Agreement from the Massachusetts e-Health Institute to the
4965 executive office.

4966 Section 4. In carrying out of this chapter, the council shall consult with various
4967 organizations of regional payers and providers in developing the health information exchange
4968 plan and annual updates and in designing, developing, disseminating and implementing the
4969 health information exchange.

4970 In carrying out this chapter, the executive office shall, to the maximum extent practicable,
4971 adopt policies that are consistent with those relating to similar subject matters adopted by the
4972 Office of the National Coordinator for Health Information Technology of the United States
4973 Department of Health and Human Services; provided, however, that nothing herein shall be
4974 construed to limit the executive office's ability to advance interoperability and other health
4975 information technology beyond the standards adopted by the ONC, including without limitation
4976 any applicable meaningful use standards.

4977 Section 5. (a) The council shall approve all expenditures from the Massachusetts Health
4978 Information Exchange Fund established under section 10. The council, in consultation with the
4979 executive office and institute, shall prepare and annually update a statewide health information

4980 exchange implementation plan. The plan shall contain a budget for the application of funds from
4981 the Massachusetts Health Information Exchange Fund.

4982 (b) Components of the plan, as updated, shall be community-based and shall assess a
4983 municipality's or region's readiness to implement an interoperable electronic health information
4984 exchange within the referral market for a defined patient population.

4985 (c) The plan as updated shall: (i) allow seamless, secure electronic exchange of health
4986 information among health care providers, health plans and other authorized users; (ii) provide
4987 consumers with secure, electronic access to their own health information; (iii) meet all applicable
4988 federal and state privacy and security requirements, including requirements imposed by the
4989 Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American
4990 Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R.
4991 §§160, 162, 164 and 170.; (iv) establish a method by which patients may choose which of their
4992 health care providers may disseminate their individually identifiable information; (v) provide
4993 public health reporting capability as required under state law; and (vi) allow reporting of health
4994 information other than identifiable patient health information for purposes of such activities as
4995 the executive office may consider necessary.

4996 (d) The plan as updated shall be consistent with the mandatory compliance date for
4997 implementation of the health information exchange under section 7 and all other requirements of
4998 this chapter. Each such plan shall be consistent with the statewide electronic health records plan
4999 developed by the institute under subsection (c) of section 6D of of chapter 40J.

5000 Section 6. Every patient shall have electronic access to such patient's health records.

5001 The executive office shall ensure that each patient will have secure electronic access to such

5002 patient's electronic health records with each of such patient's providers. The executive office
5003 shall ensure that the design of the statewide health information exchange includes the ability to
5004 transmit copies of electronic health records to patients directly or allow facilities to provide
5005 mechanisms for such patient to access such patient's own electronic health record.

5006 Section 7. All providers in the commonwealth shall implement fully interoperable
5007 electronic health records systems that connect to the statewide health information exchange. The
5008 executive office, in consultation with the institute, shall ensure that the statewide health
5009 information exchange and associated electronic health records systems comply with all state and
5010 federal privacy requirements, including those imposed by the Health Insurance Portability and
5011 Accountability Act of 1996, P.L.104-191, the American Recovery and Reinvestment Act of
5012 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R. §§160, 162 and 164.

5013 Section 8. The executive office shall prescribe by regulation penalties for non-
5014 compliance by healthcare providers with the requirements of section 7; provided, however, that
5015 the executive office may waive penalties for good cause, including, but not limited to lack of
5016 broadband internet access as provided in section 9. Penalties collected under this section shall be
5017 deposited into the Prevention and Wellness Trust Fund, established in section 2G of chapter 111.

5018 Section 9. If a provider is located in a geographic area of the commonwealth that does
5019 not have broadband internet access and, due to lack of such broadband internet access, such
5020 provider is unable to fully comply with the requirements of the health information exchange and
5021 any other health information technology requirements implemented by the executive office under
5022 this chapter, such provider may apply to the executive office for a temporary waiver of any
5023 specific requirement with which it is unable to comply. If the executive office determines that

5024 the provider is unable to comply with a requirement due to the lack of broadband internet access,
5025 the executive office may grant a waiver of such requirement; provided, however, that, upon a
5026 determination by the executive office that broadband internet access has become available to
5027 such provider since the date of the grant of the waiver, the executive office shall notify such
5028 provider of such availability. Within 180 days of such notice, such provider shall take such
5029 actions as are necessary to bring the provider into full compliance with the requirements of the
5030 health information exchange and any other health information technology requirements
5031 implemented by the executive office under this chapter.

5032 Section 10. There shall be established and set up on the books of the executive office the
5033 Massachusetts Health Information Exchange Fund, referred to in this section as the fund, for the
5034 purpose of developing a statewide health information exchange. There shall be credited to the
5035 fund any appropriations, proceeds of any bonds or notes of the commonwealth issued for the
5036 purpose, or other monies authorized by the general court and designated thereto; any federal
5037 grants or loans; any private gifts, grants or donations made available; and any income derived
5038 from the investment of amounts credited to the fund. The executive office shall seek, to the
5039 greatest extent possible, private gifts, grants and donations to the fund. The executive office shall
5040 hold the fund in an account or accounts separate from other funds. The fund shall be
5041 administered by the executive office without further appropriation. Amounts credited to the fund
5042 shall be available for reasonable expenditure by the executive office, subject to the approval of
5043 the council where such approval is required under this chapter, for such purposes as the
5044 executive office determines are necessary to support the dissemination and development of the
5045 statewide health information exchange. The secretary of administration and finance shall transfer
5046 a portion of (i) any money in the E-Health Institute Fund, (ii) any money from the ONC Health

5047 Information Exchange Cooperative Agreement, or (iii) the ONC Health Information Exchange
5048 Challenge Grant programs that is related to the implementation of the statewide health
5049 information exchange.

5050 Section 11. Any plan approved by the executive office and council or the e-Health
5051 institute, including every grantee and implementing organization that receives monies funded in
5052 whole or in part from the e-Health Institute Fund established in section 6E of chapter 40J or the
5053 Massachusetts Health Information Exchange Fund established under section 10, shall:

5054 (1) establish a mechanism to allow patients to opt-in to the health information exchange
5055 and to opt-out at any time;

5056 (2) maintain identifiable health information in physically and technologically secure
5057 environments by means including, but not limited to: prohibiting the storage or transfer of
5058 unencrypted and non-password protected identifiable health information on portable data storage
5059 devices; requiring data encryption, unique alpha-numerical identifiers and password protection;
5060 and other methods to prevent unauthorized access to identifiable health information;

5061 (3) provide patients the option of, upon request to a provider, obtaining a list of
5062 individuals and entities that have accessed their identifiable health information from that
5063 provider;

5064 (4) develop and distribute to authorized users of the health information exchange and to
5065 prospective exchange participants, written guidelines addressing privacy, confidentiality and
5066 security of health information and inform individuals: the information available through the
5067 exchange, who may access their information and the purposes for which their information may
5068 be accessed; and

5069 (5) ensure compliance with all state and federal privacy requirements, including those
5070 imposed by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the
5071 American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45
5072 C.F.R. §§160, 162 and 164.

5073 Section 12. In the event of an unauthorized access to or disclosure of individually
5074 identifiable patient health information by or through the statewide health information exchange
5075 or by or through any technology grantees or implementing organizations funded in whole or in
5076 part from the e-Health Institute Fund established in section 6E of chapter 40J or the
5077 Massachusetts Health Information Exchange Fund established in section 10, the operator of such
5078 exchange or grantee or contractor shall: (i) report the conditions of such unauthorized access or
5079 disclosure as required by the executive office; and (ii) provide notice, as defined in section 1 of
5080 chapter 93H, as soon as practicable, but not later than 10 business days after such unauthorized
5081 access or disclosure, to any person whose patient health information may have been
5082 compromised as a result of such unauthorized access or disclosure, and shall report the
5083 conditions of such unauthorized access or disclosure. Any unauthorized access or disclosures
5084 shall be punishable by the civil penalties under section 16.

5085 Section 13. The ability of any provider to transfer or access all or any part of a patient's
5086 electronic health record under this chapter shall be subject to the patient's election to participate
5087 in the electronic health information exchange as provided in section 11

5088 Section 14. The executive office, the council and the institute shall pursue and maximize
5089 all opportunities to qualify for federal financial participation under the matching grant program
5090 established under the Health Information Technology for Economic and Clinical Health Act of

5091 the American Recovery and Reinvestment Act of 2009, P.L. 111-5. The council shall consult
5092 with the office of Medicaid to maximize all opportunities to qualify any expenditure for any
5093 other federal financial participation.

5094 Section 15. The council shall file an annual report, not later than January 30, with the
5095 joint committee on health care financing, the joint committee on economic development and
5096 emerging technologies, the house and senate committees on ways and means and the clerks of
5097 the house and senate concerning the activities of the council in general and, in particular,
5098 describing the progress to date in developing a statewide health information exchange and
5099 recommending such further legislative action as it deems appropriate.

5100 Section 16. Unauthorized access to or disclosure of individually identifiable patient
5101 health information by or through the statewide health information exchange or by or through any
5102 technology grantees or implementing organizations funded in whole or in part from the from the
5103 e-Health Institute Fund established in section 6E of chapter 40J or the Massachusetts Health
5104 Information Exchange Fund established in section 10, or any associated businesses managing or
5105 in possession of such information, the operator of such exchange or grantee or contractor shall be
5106 subject to fines or penalties as determined by the executive office. The executive office shall
5107 promulgate regulations to assess fair and reasonable fines or penalties.

5108 SECTION 135. Section 14 of chapter 122 of the General Laws, as appearing in the 2010
5109 Official Edition, is hereby amended by striking out, in lines 17 and 18, the words “division of
5110 health care finance and policy” and inserting in place thereof the following words:- executive
5111 office of health and human services or a governmental unit designated by the executive office.

5112 SECTION 136. Section 32 of chapter 123 of the General Laws, as so appearing, is hereby
5113 amended by striking out, in lines 4 and 5, the words “division of health care finance and policy”
5114 and inserting in place thereof the following words:- executive office of health and human
5115 services or a governmental unit designated by the executive office.

5116 SECTION 137. Section 33 of said chapter 123, as so appearing, is hereby amended by
5117 striking out, in lines 20 and 25, the words “division of health care finance and policy” and
5118 inserting in place thereof, in each instance, the following words:- executive office of health and
5119 human services or a governmental unit designated by the executive office.

5120 SECTION 138. Section 16 of chapter 123B of the General Laws, as so appearing, is
5121 hereby amended by striking out, in lines 4 and 5, the words “division of health care finance and
5122 policy” and inserting in place thereof the following words:- executive office of health and human
5123 services or a governmental unit designated by the executive office.

5124 SECTION 139. Chapter 149 of the General Laws is hereby amended by striking out
5125 section 6D ½, as so appearing, and inserting in place thereof the following section:-

5126 Section 6D ½. No employee shall be penalized by an employer as a result of such
5127 employee’s filing of an application to the Health Safety Net Trust Fund or otherwise providing
5128 notice to the executive office of health and human services or to a health care provider in regard
5129 to the need for health care services for that employee that results in the employer being required
5130 to reimburse the fund in whole or in part.

5131 SECTION 140. Said chapter 149 is hereby further amended by striking out section 188,
5132 as so appearing, and inserting in place thereof the following section:—

5133 Section 188. (a) As used in this section, the following words, unless the context clearly
5134 requires otherwise, shall have the following meanings:--

5135 "Authority", the commonwealth health insurance connector authority.

5136 "Contributing employer", an employer that offers a group health plan, as defined in 26
5137 U.S.C. 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as
5138 defined in regulation by the authority.

5139 "Department", the department of unemployment assistance.

5140 "Employee", an individual employed by an employer subject to this chapter for at least 1
5141 month, provided that for the purpose of this section self-employed individuals shall not be
5142 considered employees.

5143 "Employer", an employing unit as defined in section 1 of chapter 151A or in section 1 of
5144 chapter 152.

5145 (b) To more equitably distribute the costs of health care provided to uninsured residents
5146 of the commonwealth, each employer that: (1) employs 11 or more full-time equivalent
5147 employees in the commonwealth and (2) is not a contributing employer shall pay a per-employee
5148 contribution at a time and in a manner prescribed by the director of unemployment assistance, in
5149 this section called the fair share employer contribution. This contribution shall be pro-rated by a
5150 fraction which shall not exceed 1, the numerator of which is the number of hours worked in the
5151 quarter by all of the employer's employees and the denominator of which is the product of the
5152 number of employees employed by an employer during that quarter multiplied by 500 hours.

5153 (c) The executive director of the authority shall, in consultation with the director of
5154 unemployment assistance, annually determine the fair share employer contribution rate based on
5155 the best available data and under the following provisions:-

5156 (1) The per-user share of private sector liability shall be calculated annually by
5157 dividing the sum of hospital liability and third-party payor liability for uncompensated care, as
5158 defined by law, by the total number of individuals in the most recently completed fiscal year
5159 whose care was reimbursed in whole or in part by the health safety net.

5160 (2) The total number of employees in the most recent fiscal year on whose behalf
5161 health care services were reimbursed in whole or in part by the health safety net, shall be
5162 calculated. In calculating this number, the authority shall use all resources available to enable it
5163 to determine the employment status of individuals for whom reimbursements were made,
5164 including quarterly wage reports maintained by the department of revenue.

5165 (3) The total number of employees as calculated in paragraph (2) shall be adjusted
5166 by multiplying that number by the percentage of employers in the commonwealth that are not
5167 contributing employers, as determined by the authority.

5168 (4) The total cost of liability associated with employees of non-contributing
5169 employers shall be determined by multiplying the number of employees, as calculated in
5170 paragraph (3) by the per-user share of private sector liability as calculated in paragraph (1).

5171 (5) The fair share employer contribution shall be calculated by dividing the total
5172 cost of liability as calculated in paragraph (4) by the total number of employees of employers
5173 that are not contributing employers, as determined by the authority.

5174 (6) The fair share employer contribution, as determined in paragraph (5) shall be
5175 adjusted annually to reflect medical inflation, using an appropriate index as determined by the
5176 authority.

5177 (7) The total dollar amount of health care services provided by physicians to non-
5178 elderly, uninsured residents of the commonwealth for which no reimbursement is made from the
5179 Health Safety Net Trust Fund shall be calculated using a survey of physicians or other data
5180 source that the authority determines is most accurate.

5181 (8) The per-employee cost of uncompensated physician care shall be calculated
5182 by dividing the dollar amount of such services, as calculated in paragraph (7) by the total number
5183 of employees of contributing employers in the commonwealth, as estimated by the authority
5184 using the most accurate data source available, as determined by the authority.

5185 (9) The annual fair share employer contribution shall be calculated by adding the
5186 fair share employer contribution as calculated in paragraph (6) and the per-employee cost of
5187 unreimbursed physician care, as calculated in paragraph (8).

5188 (10) Notwithstanding this section, the total annual fair share employer
5189 contribution shall not exceed \$295 per employee which may be made in a single payment or in
5190 equal amounts semi-annually or quarterly, at the employer's discretion.

5191 (d) The director of unemployment assistance shall determine quarterly each employer's
5192 liability for its fair share employer contribution. The director shall assess each employer liable
5193 for a fair share employer contribution in a quarter an amount based on 25 per cent of the annual
5194 fair share employer contribution rate applicable to that quarterly period and shall implement
5195 penalties for employers who fail to make contributions as required by this section. In order to

5196 reduce the administrative costs of collection of contributions, the director shall, to the extent
5197 possible, use any existing procedures implemented by the department of unemployment
5198 assistance to make similar collections. Amounts collected pursuant to this section shall be
5199 deposited in the Commonwealth Care Trust Fund, established by section 2000 of chapter 29.
5200 Before depositing the amounts, the director may deduct all administrative costs incurred by the
5201 department of unemployment assistance as a result of this section, including an amount as
5202 determined by the United States Secretary of Labor in accordance with federal cost rules. Except
5203 where inconsistent with this section, the terms and conditions of chapter 151A which are
5204 applicable to the payment and collection of contributions shall apply to the same extent to the
5205 payment and collection of any obligation under this section. The department of unemployment
5206 assistance shall promulgate regulations necessary to implement this section.

5207 (e) In promulgating regulations defining the term "contribution" under this section, no
5208 proposed regulation by the authority, except an emergency regulation, shall take effect until 60
5209 days after the proposed regulations have been transmitted to the joint committee on health care
5210 financing and the joint committee on financial services.

5211 SECTION 141. Subsection (b) of said section 188 of said chapter 149, as appearing in
5212 section 140, is hereby amended by striking out the first sentence and inserting in place thereof
5213 the following sentence:-

5214 To more equitably distribute the costs of health care provided to uninsured residents of
5215 the commonwealth, each employer that: (1) employs 21 or more full-time equivalent employees
5216 in the commonwealth and (2) is not a contributing employer shall pay a per-employee

5217 contribution at a time and in a manner prescribed by the director of unemployment assistance, in
5218 this section called the fair share employer contribution.

5219 SECTION 142. Subsection (c) of said section 188 of said chapter 149, as so appearing, is
5220 hereby amended by adding the following clause:-

5221 (11) In calculating the fair share assessment, employees who have qualifying health
5222 insurance coverage from a spouse, parent, veteran's plan, Medicare, or a plan or plans due to
5223 disability or retirement shall not be included in the numerator or denominator for purposes of
5224 determining whether an employer is a contributing employer, as defined by 114.5 CMR 16.02.
5225 The employer shall keep and maintain proof of their employee's insurance status, in a reasonable
5226 manner as defined by the authority.

5227 SECTION 143. Section 1 of chapter 150E of the General Laws, as amended by section
5228 23 of chapter 93 of the acts of 2011, is hereby amended by striking out the words "28 of chapter
5229 118G" and inserting in place thereof the following words:- 70 of chapter 118E.

5230 SECTION 144. Said section 1 of said chapter 150E of the General Laws, as so amended,
5231 is hereby further amended by striking out the words "29 of chapter 118G" and inserting in place
5232 thereof the following words:- 71 of chapter 118E.

5233 SECTION 145. Subsection (c) of section 46 of chapter 151A of the General Laws, as
5234 appearing in the 2010 Official Edition, is hereby amended by striking out clause (7) and inserting
5235 in place thereof the following 2 clauses:-

5236 (7) to the commonwealth health insurance connector, information under an interagency
5237 agreement for the administration and enforcement of sections 17 and 18 of chapter 176Q and for

5238 the administration of the fair share employer contribution requirement under section 188 of
5239 chapter 149.

5240 (7 ½) to the executive office of health and human services, information under an
5241 interagency agreement for the administration and enforcement of paragraph (4) of subsection (a)
5242 of section 69 of chapter 118E.

5243 SECTION 146. Section 13 of chapter 152 of the General Laws, as so appearing, is hereby
5244 amended by striking out, in lines 3 and 4, the words “division of health care finance and policy
5245 under the provisions of chapter one hundred and eighteen G” and inserting in place thereof the
5246 following words:- executive office of health and human services under chapter 118E or a
5247 governmental unit designated by the executive office.

5248 SECTION 147. Said section 13 of said chapter 152, as so appearing, is hereby further
5249 amended by striking out, in lines 9, 10, 16 and 21, the word “division” and inserting in place
5250 thereof, in each instance, the following words:- executive office.

5251 SECTION 148. Said section 13 of said chapter 152, as so appearing, is hereby further
5252 amended by striking out, in lines 22 and 23, the words “one hundred and eighteen G” and
5253 inserting in place thereof the following word:- 118E.

5254 SECTION 149. Said section 13 of said chapter 152, as so appearing, is hereby further
5255 amended by striking out, in line 37 and 38, the words “one hundred and eighteen G” and
5256 inserting in place thereof, in each sentence, the following word:- 118E.

5257 SECTION 150. Section 1 of chapter 175 of the General Laws, as so appearing, is hereby
5258 amended by inserting after the definition of “Net value of policies” the following definition:-

5259 “Primary care provider”, a health care professional qualified to provide general medical
5260 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
5261 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
5262 maintains continuity of care within the scope of practice.

5263 SECTION 152. Section 47B of said chapter 175, as so appearing, is hereby amended by
5264 striking out, in line 46, the word “physician” and inserting in place thereof the following word:-
5265 provider.

5266 SECTION 153. Section 47U of said chapter 175, as so appearing, is hereby amended by
5267 striking out, in lines 62 and 64, the word “physician” and inserting in place thereof, in each
5268 instance, the following word :- provider.

5269 SECTION 154. Section 108 of said chapter 175, as so appearing, is hereby amended by
5270 adding the following clause:—

5271 13. Any policy of accident and sickness shall include a premium rate adjustment based on
5272 employee participation in a qualified wellness program. The division shall determine by
5273 regulation the criteria for a qualified wellness program to determine eligibility for the rate
5274 discount. The criteria may require (i) a minimum participation in the programs by percentage, (ii)
5275 promoting healthy workplace habits, (iii) promoting health screenings, (iv) promoting health
5276 education, and (v) any other criteria that the commissioner of insurance deems reasonable.

5277 SECTION 155. Said chapter 175 is hereby further amended by inserting after section
5278 108J the following 2 sections:—

5279 Section 108L. To the maximum extent possible, carriers that offer any policy of accident
5280 and sickness insurance or any general or blanket policy of insurance shall attribute every member
5281 to a primary care provider. Members may change their primary care provider, provided that the
5282 member gives notice to the carrier.

5283 Section 108M. To the extent permissible under applicable state and federal privacy laws,
5284 carriers shall disclose patient-level data to providers in their network solely for the purpose of
5285 carrying out treatment, coordinating care among providers and managing the care of their own
5286 patient panel; provided, that an individual provider shall only receive patient-level data related to
5287 patients treated by said provider. Patient-level data shall include, but not be limited to, health
5288 care service utilization, medical expenses, and demographics.

5289 The division of insurance shall develop procedures and a standard format for disclosing
5290 such patient-level information. The division may require carriers to disclose such information
5291 through the all-payer claims database established under section 12 of chapter 12C if the division
5292 and the center for health information and analysis determine that the all-payer claims database is
5293 an efficient means to provide such information.

5294 Carriers shall make available to any provider with whom they have entered into an
5295 alternative payment contract, the contracted prices of individual health care services within such
5296 payer's network for the purpose of referrals.

5297 SECTION 158. Chapter 175 of the General Laws is hereby amended by inserting after
5298 section 47AA, the following section:—

5299 Section 47BB. (a) For the purposes of this section, “telemedicine“ as it pertains to the
5300 delivery of health care services, shall mean the use of interactive audio, video or other electronic

5301 media for the purpose of diagnosis, consultation or treatment. “Telemedicine” shall not include
5302 the use of audio-only telephone, facsimile machine or e-mail.

5303 (b) An insurer may limit coverage of telemedicine services to those health care providers
5304 in a telemedicine network approved by the insurer.

5305 (c) A contract that provides coverage for services under this section may contain a
5306 provision for a deductible, copayment or coinsurance requirement for a health care service
5307 provided through telemedicine as long as the deductible, copayment or coinsurance does not
5308 exceed the deductible, copayment or coinsurance applicable to an in-person consultation.

5309 (d) Coverage for health care services under this section shall be consistent with coverage
5310 for health care services provided through in-person consultation.

5311 SECTION 159. Section 5 of chapter 176A of the General Laws, as appearing in the 2010
5312 Official Edition, is hereby amended by striking out, in lines 34 and 35, the words “division of
5313 health care finance and policy, in this section called the division” and inserting in place thereof
5314 the following words:- executive office of health and human services, in this section called the
5315 executive office, or a governmental unit designated by the executive office.

5316 SECTION 160. Section 8A of chapter 176A of the General Laws, as so appearing, is
5317 hereby amended by striking out, in line 41, the word “physician” and inserting in place thereof
5318 the following word:- provider.

5319 SECTION 161. Subsection (c) of said section 8A of chapter 176A, as so appearing, is
5320 hereby amended by adding the following paragraph:-

5321 For the purposes of this subsection, the term “primary care provider” shall mean a health
5322 care professional qualified to provide general medical care for common health care problems
5323 who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care
5324 services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the
5325 scope of practice.

5326 SECTION 162. Paragraph (a) of section 8U of chapter 176A, as so appearing, is hereby
5327 amended by inserting after the definition of “Insured” the following definition:-

5328 “Primary care provider”, a health care professional qualified to provide general medical
5329 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
5330 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
5331 maintains continuity of care within the scope of practice.

5332 SECTION 163. Said section 8U of said chapter 176A, as so appearing, is hereby
5333 amended by striking out, in lines 64 and 66, the word “physician” and inserting in place thereof
5334 the following word in each instance:- provider.

5335 SECTION 164. Section 17 of said chapter 176A, as so appearing, is hereby amended by
5336 striking out, in lines 4 and 10, the words “division of health care finance and policy” and
5337 inserting in place thereof, in each instance, the following words:- center for health information
5338 and analysis.

5339 SECTION 165. Said chapter 176A is hereby further amended by adding the following 2
5340 sections:—

5341 Section 36. To the maximum extent possible, every non-profit hospital service
5342 corporation shall attribute every member to a primary care provider. Members may change their
5343 primary care provider, provided that the member gives notice to the carrier.

5344 Section 37. To the extent permissible under applicable state and federal privacy laws,
5345 every non-profit hospital service corporation shall disclose patient-level data to providers in their
5346 network solely for the purpose of carrying out treatment, coordinating care among providers and
5347 managing the care of their own patient panel; provided, that an individual provider shall only
5348 receive patient-level data related to patients treated by said provider. Patient-level data shall
5349 include, but not be limited to, health care service utilization, medical expenses, and
5350 demographics.

5351 The division of insurance shall develop procedures and a standard format for disclosing
5352 such patient-level information. The division may require every non-profit hospital service
5353 corporation to disclose such information through the all-payer claims database established under
5354 section 12 of chapter 12C if the division and the center for health information and analysis
5355 determine that the all-payer claims database is an efficient means to provide such information.

5356 Non-profit hospital service corporations shall make available to any provider with whom
5357 they have entered into an alternative payment contract, the contracted prices of individual health
5358 care services within such payer's network for the purpose of referrals.

5359 SECTION 166. Section 1 of chapter 176B of the General Laws, as appearing in the 2010
5360 Official Edition, is hereby amended by inserting after the definition of "Participating
5361 optometrist" the following definition:-

5362 “Primary care provider”, a health care professional qualified to provide general medical
5363 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
5364 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
5365 maintains continuity of care within the scope of practice.

5366 SECTION 167. Section 4A of said chapter 176B, as so appearing, is hereby amended by
5367 striking out, in line 43, the word “physician” and inserting in place thereof the following word:-
5368 provider.

5369 SECTION 168. Section 4U of said chapter 176B, as so appearing, is hereby amended by
5370 striking out, in lines 64 and 66, the word “physician” and inserting in place thereof the following
5371 word in each instance:- provider.

5372 SECTION 169. Said chapter 176B is hereby further amended by adding the following 2
5373 sections:-

5374 Section 23. To the maximum extent possible, every medical service corporation shall
5375 attribute every member to a primary care provider. Members may change their primary care
5376 provider, provided that the member gives notice to the carrier.

5377 Section 24. To the extent permissible under applicable state and federal privacy laws,
5378 every medical service corporation shall disclose patient-level data to providers in their network
5379 solely for the purpose of carrying out treatment, coordinating care among providers and
5380 managing the care of their own patient panel; provided, that an individual provider shall only
5381 receive patient-level data related to patients treated by said provider. Patient-level data shall
5382 include, but not be limited to, health care service utilization, medical expenses, and
5383 demographics.

5384 The division of insurance shall develop procedures and a standard format for disclosing
5385 such patient-level information. The division may require every medical service corporation to
5386 disclose such information through the all-payer claims database established under section 12 of
5387 chapter 12C if the division and the center for health information and analysis determine that the
5388 all-payer claims database is an efficient means to provide such information.

5389 Medical service corporations shall make available to any provider with whom they have
5390 entered into an alternative payment contract, the contracted prices of individual health care
5391 services within such payer's network for the purpose of referrals.

5392 SECTION 170. Section 1 of chapter 176G of the General Laws, as so appearing, is
5393 hereby amended by inserting after the definition of "Person" the following definition:-

5394 "Primary care provider", a health care professional qualified to provide general medical
5395 care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise
5396 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
5397 maintains continuity of care within the scope of practice.

5398 SECTION 171. Section 4M of said chapter 176G, as appearing in the 2010 Official
5399 Edition, is hereby amended by striking out, in line 40, the word "physician" and inserting in
5400 place thereof the following word:- provider.

5401 SECTION 172. Section 5 of said chapter 176G, as so appearing, is hereby amended by
5402 striking out, in lines 59 and 61, the word "physician" and inserting in place thereof, in each
5403 instance, the following word:- provider.

5404 SECTION 173. Chapter 176G of the General Laws is hereby amended by adding the
5405 following 2 sections:—

5406 Section 31. To the maximum extent possible, every health maintenance organization
5407 shall attribute every member to a primary care provider. Members may change their primary care
5408 provider, provided that the member gives notice to the carrier.

5409 Section 32. To the extent permissible under applicable state and federal privacy laws,
5410 every health maintenance organization shall disclose patient-level data to providers in their
5411 network solely for the purpose of carrying out treatment, coordinating care among providers and
5412 managing the care of their own patient panel; provided, that an individual provider shall only
5413 receive patient-level data related to patients treated by said provider. Patient-level data shall
5414 include, but not be limited to, health care service utilization, medical expenses, and
5415 demographics.

5416 The division of insurance shall develop procedures and a standard format for disclosing
5417 such patient-level information. The division may require every health maintenance organization
5418 to disclose such information through the all-payer claims database established under section 12
5419 of chapter 12C if the division and the center for health information and analysis determine that
5420 the all-payer claims database is an efficient means to provide such information.

5421 Health maintenance organizations shall make available to any provider with whom they
5422 have entered into an alternative payment contract, the contracted prices of individual health care
5423 services within such payer's network for the purpose of referrals.

5424 SECTION 174. Subsection (a) of section 3 of chapter 176J, as appearing in the 2010
5425 Official Edition, is hereby amended by striking out paragraph (5) and inserting in place thereof
5426 the following paragraph:-

5427 (5) A carrier shall apply a wellness program rate discount that applies to both eligible
5428 individuals and eligible small groups who follow those wellness programs that have been
5429 approved by the commissioner. If a carrier establishes a wellness program rate discount every
5430 eligible insured following the wellness program shall be subject to the applicable wellness
5431 program rate discount. The division shall determine by regulation the criteria for qualifying for
5432 the rate discount. The criteria may require (i) a minimum participation in the programs by
5433 percentage, (ii) promoting healthy workplace habits, (iii) promoting health screenings, (iv)
5434 promoting health education and (v) any other criteria that the commissioner of insurance deems
5435 reasonable.

5436 SECTION 175. Section 6 of said chapter 176J, as amended by section 20 of chapter 142
5437 of the acts of 2011, is hereby further amended by striking out the figure “90”, each time it
5438 appears, and inserting in place thereof the following figure:- 89.

5439 SECTION 176. Said section 6 of said chapter 176J, as so amended, is hereby further
5440 amended by striking out the figure “89”, as inserted by section 175, and inserting in place
5441 thereof, in each instance, the following figure:- 88.

5442 SECTION 177. Said chapter 176J is hereby further amended by striking out section 11,
5443 as appearing in the 2010 Official Edition, and inserting in place thereof the following:-

5444 Section 11. (a) A carrier that offers a health benefit plan that: (i) provides or arranges for
5445 the delivery of health care services through a closed network of health care providers; and (ii) as

5446 of the close of any preceding calendar year, has a combined total of 5,000 or more eligible
5447 individuals, eligible employees and eligible dependents, who are enrolled in health benefit plans
5448 sold, issued, delivered, made effective or renewed to qualified small businesses or eligible
5449 individuals, shall offer to all eligible individuals and small businesses in at least 1 geographic
5450 area at least 1 plan with either:

5451 (1) a reduced or selective network of providers;

5452 (2) a smart tiering plan in which health services are tiered and member cost sharing is based
5453 on the tier placement of the services; or,

5454 (3) a plan in which providers are tiered and member cost sharing is based on the tier
5455 placement of the provider.

5456 The commissioner of insurance shall annually determine a base premium rate discount of
5457 at least 14 per cent for the reduced or selective or tiered network plan compared to the base
5458 premium of the carrier's most actuarially similar plan with the carrier's non-selective or non-
5459 tiered network of providers. The savings may be achieved by means including, but not limited to:
5460 (i) the exclusion of providers with similar or lower quality based on the standard quality measure
5461 set with higher health status adjusted total medical expenses or relative prices, as determined
5462 under section 10 of chapter 12C; or (ii) increased member cost-sharing for members who utilize
5463 providers for non-emergency services with similar or lower quality based on the standard quality
5464 measure set and with higher health status adjusted total medical expenses or relative prices, as
5465 determined under said section 10 of said chapter 12C.

5466 The commissioner may apply waivers to the base premium rate discount determined by
5467 the commissioner under this section to carriers who receive 80 per cent or more of their incomes

5468 from government programs or which have service areas which do not include either Suffolk or
5469 Middlesex counties and who were first admitted to do business by the division of insurance on
5470 January 1, 1988, as health maintenance organizations under chapter 176G.

5471 (b) A tiered network plan shall only include variations in member cost-sharing between
5472 provider tiers which are reasonable in relation to the premium charged and ensure adequate
5473 access to covered services. Carriers shall tier providers based on quality performance as
5474 measured by the standard quality measure set and by cost performance as measured by health
5475 status adjusted total medical expenses and relative prices. Where applicable quality measures are
5476 not available, tiering may be based solely on health status adjusted total medical expenses or
5477 relative prices or both. Smart tiering plans may take into account the number of services
5478 performed each year by the provider. For smart tiering plans, if a medically necessary and
5479 covered service is available at not more than 5 facilities in the state, as determined by the health
5480 policy commission, that service shall not be placed into the most expensive cost-sharing tier.

5481 The commissioner shall promulgate regulations requiring the uniform reporting of tiering
5482 information, including, but not limited to, requiring at least 90 days before the proposed effective
5483 date of any tiered network plan or any modification in the tiering methodology for any existing
5484 tiered network plan, the reporting of a detailed description of the methodology used for tiering
5485 providers, including: the statistical basis for tiering; a list of providers to be tiered at each
5486 member cost-sharing level; a description of how the methodology and resulting tiers will be
5487 communicated to each network provider, eligible individuals and small groups; and a description
5488 of the appeals process a provider may pursue to challenge the assigned tier level.

5489 (c) The commissioner shall determine network adequacy for a tiered network plan based
5490 on the availability of sufficient network providers in the carrier's overall network of providers.

5491 (d) The commissioner shall determine network adequacy for a selective network plan
5492 based on the availability of sufficient network providers in the carrier's selective network.

5493 (e) In determining network adequacy under this section the commissioner of insurance
5494 may take into consideration factors such as the location of providers participating in the plan and
5495 employers or members that enroll in the plan, the range of services provided by providers in the
5496 plan and plan benefits that recognize and provide for extraordinary medical needs of members
5497 that may not be adequately dealt with by the providers within the plan network.

5498 (f) Carriers may: (i) reclassify provider tiers; and (ii) determine provider participation in
5499 selective and tiered plans not more than once per calendar year except that carriers may
5500 reclassify providers from a higher cost tier to a lower cost tier or add providers to a selective
5501 network at any time. If the carrier reclassifies provider tiers or providers participating in a
5502 selective plan during the course of an account year, the carrier shall provide affected members of
5503 the account with information regarding the plan changes at least 30 days before the changes take
5504 effect. Carriers shall provide information on their websites about any tiered or selective plan,
5505 including but not limited to, the providers participating in the plan, the selection criteria for those
5506 providers and where applicable, the tier in which each provider is classified.

5507 (g) A smart tiering plan shall be a tiering product, which offers a cost-sharing differential
5508 based on services rather than facilities providing services. A service covered in a smart tiering
5509 plan may be reimbursed through bundled payments for acute and chronic diseases.

5510 (h) The division of insurance shall review smart tiering plans in a manner consistent with
5511 other products offered in the commonwealth. The division of insurance may disapprove a smart
5512 tiering plan if it determines that the carrier differentiated cost-sharing obligations solely based on
5513 the provider. There shall be a rebuttable presumption that a plan has violated this subsection if
5514 the cost-sharing obligation for all services provided by a provider, including a health care
5515 facility, accountable care organization, patient centered medical home, or provider organization,
5516 is the same.

5517 (i) The commissioner when reviewing smart tiering plans shall promote the following
5518 goals: (1) avoid creating consumer confusion; (2) minimize the administrative burdens on payers
5519 and providers in implementing smart tiering plans; and (3) allow patients to get their services in
5520 the proper locations.

5521 (j) The division of insurance shall report annually specific findings and legislative
5522 recommendations, including the following: (1) the utilization trends of eligible employers and
5523 eligible individuals enrolled in plans offered under this section; (2) the extent to which tiered
5524 product offerings have reduced health care costs for patients and employers; (3) the effects that
5525 tiered product offerings have on patient education relating to health care costs and quality; (4)
5526 the effects that tiered product offerings have on patient utilization of local hospitals and the
5527 resulting impact on overall state health care costs, including the state's compliance with the
5528 health care cost growth benchmark established under section 9 of chapter 6D; (5) opportunities
5529 to incentivize tiered product offerings for both health systems and employers. The report shall
5530 also include the number of members enrolled by plan type, aggregate demographic, geographic
5531 information on all members and the average direct premium claims incurred, as defined in
5532 section 6, for selective and tiered network products compared to non-selective and non-tiered

5533 products. The report shall be submitted to clerks of the house of representatives and the senate,
5534 the senate and house committees on ways and means and the joint committee on health care
5535 financing.

5536 SECTION 178. Section 12 of said chapter 176J, as appearing in the 2010 Official
5537 Edition, is hereby amended by striking out, in line 59 and 60, the words “division of health care
5538 finance and policy” and inserting in place thereof the following words:- center for health
5539 information and analysis.

5540 SECTION 179. Said section 12 of said chapter 176J, as so appearing, is hereby further
5541 amended by adding the following subsection:—

5542 (h) Any rates offered by a carrier to a certified group purchasing cooperative under this
5543 section shall be based on those group base premium rates that apply to individuals and small
5544 employer groups enrolling outside the group purchasing cooperative but may differ based on:

5545 (1) a benefit rate adjustment factor that would apply to the certified group
5546 purchasing cooperative product if its covered benefits are different than those that apply outside
5547 the certified group purchasing cooperative;

5548 (2) a cooperative adjustment factor that would reflect the relative difference in
5549 the projected experience of the members projected to be enrolled in health benefit plans through
5550 the certified group purchasing cooperative relative to the projected experience of the members
5551 projected to be enrolled in health benefit plans outside the certified group purchasing
5552 cooperative; or

5553 (3) any other rate adjustment factor resulting in a discount of up to 10 per cent.
5554 Any adjustment greater than 10 per cent shall require prior approval in writing from the
5555 commissioner.

5556 SECTION 180. Said chapter 176J is hereby further amended by adding the following 2
5557 sections:-

5558 Section 16. To the maximum extent possible, carriers shall attribute every member to a
5559 primary care provider. Members may change their primary care provider, provided that the
5560 member gives notice to the carrier.

5561 Section 17. To the extent permissible under applicable state and federal privacy laws,
5562 every carrier shall disclose patient-level data to providers in their network solely for the purpose
5563 of carrying out treatment, coordinating care among providers and managing the care of their own
5564 patient panel; provided, that an individual provider shall only receive patient-level data related to
5565 patients treated by said provider. Patient-level data shall include, but not be limited to, health
5566 care service utilization, medical expenses, and demographics.

5567 The division of insurance shall develop procedures and a standard format for disclosing
5568 such patient-level information. The division may require carriers to disclose such information
5569 through the all-payer claims database established under section 12 of chapter 12C if the division
5570 and the center for health information and analysis determine that the all-payer claims database is
5571 an efficient means to provide such information.

5572 Carriers shall make available to any provider with whom they have entered into an
5573 alternative payment contract, the contracted prices of individual health care services within such
5574 payer's network for the purpose of referrals.

5575 SECTION 181. Section 5 of chapter 176M of the General Laws, as appearing in the 2010
5576 Official Edition, is hereby amended by striking out, in lines 94 to 96, inclusive, the words
5577 “division of health care finance and policy established under chapter one hundred and eighteen
5578 G” and inserting in place thereof the following words:- center for health information and analysis
5579 established under chapter 12C.

5580 SECTION 182. Said section 5 of said chapter 176M, as so appearing, is hereby further
5581 amended by striking out, in line 99, the word “division” and inserting in place thereof the
5582 following word:- center.

5583 SECTION 183. Section 1 of said chapter 176O of the General Laws, as so appearing, is
5584 hereby amended by striking out the definition of “Behavioral health manager” and inserting in
5585 place thereof the following definition:-

5586 “Behavioral health manager”, a company, organized under the law of the commonwealth
5587 or organized under the laws of another state and qualified to do business in the commonwealth,
5588 that has entered into a contractual arrangement with a carrier to provide or arrange for the
5589 provision of behavioral, substance use disorder and mental health services to voluntarily enrolled
5590 member of the carrier.

5591 SECTION 184. Said section 1 of said chapter 176O , as so appearing, is hereby further
5592 amended by inserting after the definition of “Division” the following definition:

5593 “Downside risk”, the risk taken on by a provider organization as part of an alternate
5594 payment contract with a carrier or other payer where the provider organization is responsible for
5595 either the full or partial costs of treating a group of patients that exceeds a contract’s budgeted
5596 payment arrangements.

5597 SECTION 185. Said section 1 of said chapter 176O, as so appearing, is hereby further
5598 amended by striking out the definition of “Emergency medical condition” and inserting in place
5599 thereof the following definition:-

5600 “Emergency medical condition”, a medical condition, whether physical, behavioral,
5601 related to substance use disorder, or mental, manifesting itself by symptoms of sufficient
5602 severity, including severe pain, that the absence of prompt medical attention could reasonably be
5603 expected by a prudent layperson who possesses an average knowledge of health and medicine, to
5604 result in placing the health of the insured or another person in serious jeopardy, serious
5605 impairment to body function or serious dysfunction of any body organ or part or, with respect to
5606 a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42
5607 U.S.C. section 1395dd(e)(1)(B).

5608 SECTION 186. Said section 1 of said chapter 176O, as so appearing, is hereby further
5609 amended by striking out the definition of “Health care services” and inserting in place thereof
5610 the following definition:-

5611 “Health care services”, services for the diagnosis, prevention, treatment, cure or relief of
5612 a physical, behavioral, substance use disorder or mental health condition, illness, injury or
5613 disease.

5614 SECTION 187. Said section 1 of said chapter 176O, as so appearing, is hereby further
5615 amended by inserting after the definition of “Person” the following definition:-

5616 “Primary care provider”, a health care professional qualified to provide general medical
5617 care for common health care problems who: (i) supervises, coordinates, prescribes, or otherwise

5618 provides or proposes health care services; (ii) initiates referrals for specialist care; and (iii)
5619 maintains continuity of care within the scope of practice.

5620 SECTION 188. Said section 1 of said chapter 176O, as so appearing, is hereby further
5621 amended by inserting after the definition of “Retrospective review” the following definition:-

5622 “Risk-Bearing Provider Organization,” a provider organization that manages the
5623 treatment of a group of patients and bears the downside risk according to the terms of an
5624 alternate payment contract.

5625 SECTION 189. Section 2 said of chapter 176O, as so appearing, is hereby amended by
5626 striking out, in line 22, the word “division” and inserting in place thereof the following word:-
5627 center.

5628 SECTION 190. Section 5B of said chapter 176O, as so appearing, is hereby amended by
5629 striking out, in lines 11 and 12, the words “the division of health care finance and policy, the
5630 health care quality and cost council” and inserting in place thereof the following words:- the
5631 center for health information and analysis.

5632 SECTION 191. Said chapter 176O is hereby amended by inserting after section 5B the
5633 following section:-

5634 Section 5C. If the commissioner determines that a carrier is neglecting to comply with the
5635 coding standards and guidelines under this chapter in the form and within the time required the
5636 commissioner shall notify the carrier of such neglect. If the carrier does not come into
5637 compliance within a period determined by the commissioner, the carrier shall be fined up to
5638 \$5000 for each day during which such neglect continues.

5639 SECTION 192. Subsection (a) of section 6 of said chapter 176O, as appearing in the
5640 2010 Official Edition, is hereby amended by striking out clauses (3) and (4) and inserting in
5641 place thereof the following 2 clauses:-

5642 (3) the limitations on the scope of health care services and any other benefits to be
5643 provided, including: (i) all restrictions relating to preexisting condition exclusions; (ii) an
5644 explanation of any facility fee, allowed amount, co-insurance, copayment, deductible or other
5645 amount that the insured may be responsible to pay to obtain covered benefits from network or
5646 out-of-network providers; and (iii) the toll-free telephone number and website established by the
5647 carrier under section 22 and an explanation of the information that an insured may obtain
5648 through such toll-free telephone number and website;

5649 (4) the locations where, and the manner in which, health care services and other benefits
5650 may be obtained, including: (i) an explanation that whenever a proposed admission, procedure or
5651 service that is a medically necessary covered benefit is not available to an insured within the
5652 carrier's network, the carrier shall cover the out-of-network admission, procedure or service and
5653 the insured will not be responsible to pay more than the amount which would be required for
5654 similar admissions, procedures or services offered within the carrier's network; and (ii) an
5655 explanation that whenever a location is part of the carrier's network, that the carrier shall cover
5656 medically necessary covered benefits delivered at that location and the insured shall not be
5657 responsible to pay more than the amount required for network services even if part of the
5658 medically necessary covered benefits are performed by out-of-network providers unless the
5659 insured has a reasonable opportunity to choose to have the service performed by a network
5660 provider.

5661 SECTION 193. Clause (1) of subsection (a) of section 7 of said chapter 176O, as so
5662 appearing, is hereby amended by striking out, in lines 18 and 19, the words “6 of chapter 118G”
5663 and inserting in place thereof the following words:- 10 of chapter 12C.

5664 SECTION 194. Said section 7 of said chapter 176O, as so appearing, is hereby further
5665 amended by striking out, in lines 20 and 21, the words “6 of said chapter 118G” and inserting in
5666 place thereof the following words:- 10 of said chapter 12C.

5667 SECTION 195. Said section 7 of said chapter 176O, as so appearing in the 2010 Official
5668 Edition, is hereby further amended by striking out, in line 48, the word “physician” and inserting
5669 in place thereof the following word:- provider.

5670 SECTION 196. Section 9A of said chapter 176O, as so appearing, is hereby amended by
5671 striking out, in line 25, the words “6 of chapter 118G” and inserting in place thereof the
5672 following words:- 10 of chapter 12C; and.

5673 SECTION 197. Said section 9A of said chapter 176O, as so appearing, is hereby
5674 amended by adding the following 2 subsections:—

5675 (d) limits the ability of either the carrier or the health care provider from disclosing the
5676 allowed amount and fees of services to an insured or insured’s treating health care provider.

5677 (e) limits the ability of either the carrier or the health care provider from disclosing out-
5678 of-pocket costs to an insured.

5679 SECTION 198. Said chapter 176O is hereby further amended by inserting after section
5680 9A the following section:-

5681 Section 9B. Carriers shall not be permitted to enter into or continue alternate payment
5682 arrangements involving downside risk with provider organizations that have not received a risk
5683 certificate under chapter 176U.

5684 SECTION 199. Section 12 of said chapter 176O, as appearing in the 2010 Official
5685 Edition, is hereby amended by striking out subsection (a) and inserting in place thereof the
5686 following subsection:-

5687 (a) Utilization review conducted by a carrier or a utilization review organization shall be
5688 conducted under a written plan, under the supervision of a physician and staffed by appropriately
5689 trained and qualified personnel and shall include a documented process to: (i) review and
5690 evaluate its effectiveness; (ii) ensure the consistent application of utilization review criteria; and
5691 (iii) ensure the timeliness of utilization review determinations.

5692 A carrier or utilization review organization shall adopt utilization review criteria and
5693 conduct all utilization review activities under said criteria. The criteria shall be, to the maximum
5694 extent feasible, scientifically derived and evidence-based, and developed with the input of
5695 participating physicians, consistent with the development of medical necessity criteria under
5696 section 16. Utilization review criteria shall be applied consistently by a carrier or a utilization
5697 review organization and made easily accessible and up-to-date on a carrier or utilization review
5698 organization's website to subscribers, health care providers and the general public; provided,
5699 however, that a carrier shall not be required to disclose licensed, proprietary criteria purchased
5700 by a carrier or utilization review organization on its website, but must disclose such criteria to a
5701 provider or subscriber upon request. If a carrier or utilization review organization intends either
5702 to implement a new preauthorization requirement or restriction or amend an existing requirement

5703 or restriction, the carrier or utilization review organization shall ensure that the new or amended
5704 requirement or restriction shall not be implemented unless the carrier's or utilization review
5705 organization's website has been updated to reflect the new or amended requirement or
5706 restriction.

5707 Adverse determinations rendered by a program of utilization review or other denials of
5708 requests for health services, shall be made by a person licensed in the appropriate specialty
5709 related to such health service and, if applicable, by a provider in the same licensure category as
5710 the ordering provider.

5711 SECTION 200. Said section 12 of said chapter 176O, as so appearing, is hereby further
5712 amended by adding the following subsection:-

5713 (f) Upon request by an insured or insured's treating health care provider, a carrier or
5714 utilization review organization shall make a determination regarding whether a proposed
5715 admission, procedure or service is medically necessary within 7 working days of obtaining all
5716 necessary information, except that a carrier or utilization review organization may choose not to
5717 perform such a review if the carrier or utilization review organization determines that the
5718 admission, procedure or service will be covered. Nothing in this subsection shall:- (i) require a
5719 treating health care provider to obtain information regarding whether a proposed admission,
5720 procedure or service is medically necessary on behalf of an insured; (ii) restrict the ability of a
5721 carrier or utilization review organization to deny a claim for an admission, procedure or service
5722 if the admission, procedure or service was not medically necessary, based on information
5723 provided at the time of claim; or (iii) shall restrict the ability of a carrier or utilization review

5724 organization to deny a claim for an admission, procedure or service if other terms and conditions
5725 of coverage are not met at the time of service or time of claim.

5726 SECTION 201. Said chapter 176O is hereby further amended by striking out section 15,
5727 as so appearing, and inserting in place thereof the following section:—

5728 Section 15. (a) A carrier that allows or requires the designation of a primary care provider
5729 shall notify an insured at least 30 days before the disenrollment of such insured's primary care
5730 provider and shall permit such insured to continue to be covered for health services, consistent
5731 with the terms of the evidence of coverage, by such primary care provider for at least 30 days
5732 after said provider is disenrolled, other than disenrollment for quality-related reasons or for
5733 fraud. Such notice shall also include a description of the procedure for choosing an alternative
5734 primary care provider.

5735 (b) A carrier shall allow any female insured who is in her second or third trimester of
5736 pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled,
5737 other than disenrollment for quality-related reasons or for fraud, to continue treatment with said
5738 provider, consistent with the terms of the evidence of coverage, for the period up to and
5739 including the insured's first postpartum visit.

5740 (c) A carrier shall allow any insured who is terminally ill and whose provider in
5741 connection with said illness is involuntarily disenrolled, other than disenrollment for quality-
5742 related reasons or for fraud, to continue treatment with said provider, consistent with the terms of
5743 the evidence of coverage, until the insured's death.

5744 (d) A carrier shall provide coverage for health services for up to 30 days from the
5745 effective date of coverage to a new insured by a provider who is not a participating provider in

5746 the carrier's network if: (1) the insured's employer only offers the insured a choice of carriers in
5747 which said provider is not a participating provider, and (2) said provider is providing the insured
5748 with an ongoing course of treatment or is the insured's primary care provider. With respect to an
5749 insured in her second or third trimester of pregnancy, this subsection shall apply to services
5750 rendered through the first postpartum visit. With respect to an insured with a terminal illness, this
5751 subsection shall apply to services rendered until death.

5752 (e) A carrier may condition coverage of continued treatment by a provider under
5753 subsections (a) to (d), inclusive, upon the provider's agreeing: (1) to accept reimbursement from
5754 the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to
5755 impose cost sharing with respect to the insured in an amount that would exceed the cost sharing
5756 that could have been imposed if the provider had not been disenrolled; (2) to adhere to the
5757 quality assurance standards of the carrier and to provide the carrier with necessary medical
5758 information related to the care provided; and (3) to adhere to such carrier's policies and
5759 procedures, including procedures regarding referrals, obtaining prior authorization and providing
5760 services under a treatment plan, if any, approved by the carrier. Nothing in this subsection shall
5761 be construed to require the coverage of benefits that would not have been covered if the provider
5762 involved remained a participating provider.

5763 (f) A carrier that requires an insured to designate a primary care provider shall allow such
5764 a primary care provider to authorize a standing referral for specialty health care provided by a
5765 health care provider participating in such carrier's network when (1) the primary care provider
5766 determines that such referrals are appropriate, (2) the provider of specialty health care agrees to a
5767 treatment plan for the insured and provides the primary care provider with all necessary clinical
5768 and administrative information on a regular basis, and (3) the health care services to be provided

5769 are consistent with the terms of the evidence of coverage. Nothing in this section shall be
5770 construed to permit a provider of specialty health care who is the subject of a referral to
5771 authorize any further referral of an insured to any other provider without the approval of the
5772 insured's carrier.

5773 (g) No carrier shall require an insured to obtain a referral or prior authorization from a
5774 primary care provider for specialty care provided by an obstetrician, gynecologist, certified
5775 nurse-midwife or family practitioner participating in such carrier's health care provider network
5776 for the following: (1) annual preventive gynecologic health examinations, including any
5777 subsequent obstetric or gynecological services determined by such obstetrician, gynecologist,
5778 certified nurse-midwife or family practitioner to be medically necessary as a result of such
5779 examination; (2) maternity care; and (3) medically necessary evaluations and resultant health
5780 care services for acute or emergency gynecological conditions. No carrier shall require higher
5781 copayments, coinsurance, deductibles or additional cost sharing arrangements for such services
5782 provided to such insureds in the absence of a referral from a primary care provider. Carriers may
5783 establish reasonable requirements for participating obstetricians, gynecologists, certified nurse-
5784 midwives or family practitioners to communicate with an insured's primary care provider
5785 regarding the insured's condition, treatment and need for follow-up care. Nothing in this section
5786 shall be construed to permit an obstetrician, gynecologist, certified nurse-midwife or family
5787 practitioner to authorize any further referral of an insured to any other provider without the
5788 approval of the insured's carrier.

5789 (h) A carrier shall provide coverage of pediatric specialty care, including mental health
5790 care, by persons with recognized expertise in specialty pediatrics to insureds requiring such
5791 services.

5792 (i) A carrier, including a dental or vision carrier, shall provide health, dental or vision
5793 care providers applying to be participating providers who are denied such status with a written
5794 reason or reasons for denial of such application.

5795 (j) No carrier shall make a contract with a health care provider which includes a provision
5796 permitting termination without cause. A carrier shall provide a written statement to a provider of
5797 the reason or reasons for such provider's involuntary disenrollment.

5798 (k) A carrier, including a dental or vision carrier, shall provide insureds, upon request,
5799 interpreter and translation services related to administrative procedures.

5800 SECTION 202. Section 16 of said chapter 176O, as so appearing, is hereby amended by
5801 striking out subsection (b) and inserting in place thereof the following subsection:-

5802 (b) A carrier shall be required to pay for health care services ordered by a treating
5803 physician or a primary care provider if: (1) the services are a covered benefit under the insured's
5804 health benefit plan; and (2) the services are medically necessary. A carrier may develop
5805 guidelines to be used in applying the standard of medical necessity, as defined in this subsection.
5806 Any such medical necessity guidelines utilized by a carrier in making coverage determinations
5807 shall be: (i) developed with input from practicing physicians and participating providers in the
5808 carrier's or utilization review organization's service area; (ii) developed under the standards
5809 adopted by national accreditation organizations; (iii) updated at least biennially or more often as
5810 new treatments, applications and technologies are adopted as generally accepted professional
5811 medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier
5812 shall consider the individual health care needs of the insured. Any such medical necessity
5813 guidelines criteria shall be applied consistently by a carrier or a utilization review organization

5814 and made easily accessible and up-to-date on a carrier or utilization review organization's
5815 website to subscribers, health care providers and the general public. If a carrier or utilization
5816 review organization intends either to implement a new medical necessity guideline or amend an
5817 existing requirement or restriction, the carrier or utilization review organization shall ensure that
5818 the new or amended requirement or restriction shall not be implemented unless the carrier's or
5819 utilization review organization's website has been updated to reflect the new or amended
5820 requirement or restriction.

5821 SECTION 203. Section 20 of said chapter 176O, as so appearing, is hereby amended by
5822 striking out, in lines 19 and 22, the words "care physician" and inserting in place thereof, in each
5823 instance, the following words:- "care provider".

5824 SECTION 204. Section 21 of said chapter 176O, as so appearing, is hereby amended by
5825 striking out, in lines 109 and 110, the words "division of health care finance and policy for use
5826 under section 6 of chapter 118G" and inserting in place thereof the following words:- center for
5827 health information and analysis for use under section 10 of chapter 12C.

5828 SECTION 205. Said section 21 of said chapter 176O, as so appearing, is hereby further
5829 amended by adding the following section:

5830 (e) The commissioner may waive specific reporting requirements in this section for
5831 classes of carriers for which the commissioner deems such reporting requirements to be
5832 inapplicable; provided, however, that the commissioner shall provide written notice of any such
5833 waiver to the joint committee of health care financing and the house and senate committees on
5834 ways and means.

5835 SECTION 206. Said chapter 176O is hereby further amended by adding the following 2
5836 sections:-

5837 Section 23. All carriers shall establish a toll-free telephone number and website that
5838 enables consumers to request and obtain from the carrier, within 2 working days, the estimated
5839 or maximum allowed amount or charge for a proposed admission, procedure or service and the
5840 estimated amount the insured will be responsible to pay for a proposed admission, procedure or
5841 service that is a medically necessary covered benefit, based on the information available to the
5842 carrier at the time the request is made, including any facility fee, copayment, deductible,
5843 coinsurance or other out of pocket amount for any covered health care benefits; provided, that
5844 the insured shall not be required to pay more than the disclosed amounts for the covered health
5845 care benefits that were actually provided; provided, however, that nothing in this section shall
5846 prevent carriers from imposing cost sharing requirements disclosed in the insured's evidence of
5847 coverage for unforeseen services that arise out of the proposed admission, procedure or service;
5848 and provided further, that the carrier shall alert the insured that these are estimated costs, and that
5849 the actual amount the insured will be responsible to pay may vary due to unforeseen services
5850 that arise out of the proposed admission, procedure or service.

5851 Section 24. (a) All risk-bearing provider organizations certified under chapter 176U
5852 shall create internal appeals processes. The appeals processes shall be available to the public in
5853 written format and, by request, in electronic format.

5854 (b) The internal appeals processes in subsection (a) shall be completed in a period not
5855 longer than 14 days; provided, however, that an expedited internal appeal shall be completed in a
5856 period not longer than 3 days for a patient with an urgent medical need including, but not limited

5857 to, terminal illness or emergency situations, as defined through regulations by the office of
5858 patient protection. During the appeals process, the risk-bearing provider organization shall not:
5859 (i) prevent a patient from seeking medical opinions outside of that organization; or (ii) terminate
5860 any medical services being provided to the patient, including medical services which began prior
5861 to the appeal and are the subject of such appeal. The decision on the appeal shall be in writing
5862 and shall notify the patient of the right to file a further external appeal.

5863 (c) Risk-bearing provider organizations shall inform any patient of the right to designate a third
5864 party to advocate on the patient's behalf during the appeals process including, but not limited to,
5865 a spouse or other family member, an attorney of record or a legal guardian. If the patient does not
5866 elect a person to serve as his or her advocate such provider organization shall offer to contact the
5867 office of patient protection and the office of patient protection may designate an ombudsman to
5868 advocate on the patient's behalf.

5869 (d) The office of patient protection shall establish by regulation an external review
5870 process for the review of grievances submitted by or on behalf of patients of risk-bearing
5871 provider organizations. The process shall specify the maximum amount of time for the
5872 completion of a determination and review after a grievance is submitted and shall include the
5873 right to have benefits continued pending appeal. The office of patient protection shall establish
5874 expedited review procedures applicable to emergency and urgent care situations

5875 (e) The office of patient protection shall promulgate regulations necessary to implement
5876 this section.

5877 SECTION 207. Section 23 of chapter 176O, inserted by section 206, is hereby amended
5878 by striking out the words “within 2 working days” and inserting in place thereof the following
5879 words:- in real time.

5880 SECTION 207A. Chapter 176O is hereby amended by adding the following 3 sections:—

5881 Section 25. (a) A payer or any entity acting for a payer under contract, when requiring
5882 prior authorization for a health care service or benefit, shall use and accept only the prior
5883 authorization forms designated for the specific types of services and benefits developed under
5884 subsection (c).

5885 (b) If a payer or any entity acting for a payer under contract fails to use or accept the required
5886 prior authorization form, or fails to respond within 2 business days after receiving a completed
5887 prior authorization request from a provider, pursuant to the submission of the prior authorization
5888 form developed as described in subsection (c), the prior authorization request shall be deemed to
5889 have been granted.

5890 (c) The division shall develop and implement uniform prior authorization forms for
5891 different health care services and benefits. The forms shall cover such health care services and
5892 benefits including, but not limited to, provider office visits, prescription drug benefits, imaging
5893 and other diagnostic testing, laboratory testing and any other health care services. The division
5894 shall develop forms for different kinds of services as it deems necessary or appropriate; provided
5895 that, all payers and any entities acting for a payer under contract shall use the uniform form
5896 designated by the division for the specific type of service. Six months after the full set of forms
5897 has been developed, every provider shall use the appropriate uniform prior authorization form to
5898 request prior authorization for coverage of the health care service or benefit and every payer or

5899 any entity acting for a payer under contract shall accept the form as sufficient to request prior
5900 authorization for the health care service or benefit.

5901 Nothing in this section shall prohibit a payer or any entity acting for a payer under
5902 contract from using a prior authorization methodology that utilizes an internet webpage, internet
5903 webpage portal, or similar electronic, internet, and web-based system in lieu of a paper form,
5904 provided that it is consistent with the paper form, developed pursuant to subsection (c).

5905 (d) The prior authorization forms developed under subsection (c) shall:

5906 (1) not exceed 2 pages;

5907 (2) be made electronically available; and

5908 (3) be capable of being electronically accepted by the payer after being
5909 completed.

5910 (e) The division, in developing the forms, shall:

5911 (1) seek input from interested stakeholders and shall seek to use forms that have
5912 been mutually agreed upon by payers and providers;

5913 (2) ensure that the forms are consistent with existing prior authorization forms
5914 established by the federal Centers for Medicare and Medicaid Services; and

5915 (3) consider other national standards pertaining to electronic prior authorization.

5916 (f) Nothing in this section shall limit a health plan from requiring prior authorization for
5917 services.

5918 Section 26. The commissioner shall establish standardized processes and procedures
5919 applicable to all health care providers and payers for the determination of a patient's health
5920 benefit plan eligibility at or prior to the time of service. As part of such processes and
5921 procedures, the commissioner shall (i) require payers to implement automated approval systems
5922 such as decision support software in place of telephone approvals for specific types of services
5923 specified by the commissioner and (ii) require establishment of an electronic data exchange to
5924 allow providers to determine eligibility at or prior to the point of care.

5925 Section 27. The division shall develop a common summary of payments form to be used
5926 by all health care payers in the commonwealth that is provided to health care consumers with
5927 respect to provider claims submitted to a payer and written in an easily readable and
5928 understandable format showing the consumer's responsibility, if any, for payment of any portion
5929 of a health care provider claim; provided that the division shall allow the development of forms
5930 to be exchanged through electronic means. The division shall consult with stakeholders to
5931 develop these forms.

5932 SECTION 208. Section 1 of chapter 176Q of the General Laws, as appearing in the 2010
5933 Official Edition, is hereby amended by inserting after the definition of "Connector seal of
5934 approval" the following definition:-

5935 "Dependent", the spouse and children of any employee if such persons would qualify for
5936 dependent status under the Internal Revenue Code or for whom a support order could be granted
5937 under chapters 208, 209 or 209C.

5938 SECTION 209. Said section 1 of said chapter 176Q, as so appearing, is hereby further
5939 amended by striking out the definition of "division".

5940 SECTION 210. Said section 1 of said chapter 176Q, as so appearing, is hereby further
5941 amended by inserting after the definition of “Eligible small groups” the following 2 definitions:-

5942 “Fiscal year”, the 12 month period during which a hospital keeps its accounts and which
5943 ends in the calendar year by which it is identified.

5944 “Free care”, the following medically necessary services provided to individuals
5945 determined to be financially unable to pay for their care, in whole or in part, under applicable
5946 regulations of the connector: (1) services provided by acute hospitals; (2) services provided by
5947 community health centers; and (3) patients in situations of medical hardship in which major
5948 expenditures for health care have depleted or can reasonably be expected to deplete the financial
5949 resources of the individual to the extent that medical services cannot be paid, as determined by
5950 regulations of the connector.

5951 SECTION 211. Said section 1 of said chapter 176Q, as so appearing, is hereby further
5952 amended by inserting after the definition of “Mandated benefits” the following 2 definitions:-

5953 “Medically necessary services”, medically necessary inpatient and outpatient services as
5954 mandated under Title XIX of the Federal Social Security Act; provided, that “medically
5955 necessary services” shall not include: (1) non-medical services, such as social, educational and
5956 vocational services; (2) cosmetic surgery; (3) canceled or missed appointments; (4) telephone
5957 conversations and consultations; (5) court testimony; (6) research or the provision of
5958 experimental or unproven procedures including, but not limited to, treatment related to sex-
5959 reassignment surgery and pre-surgery hormone therapy; and (7) the provision of whole blood;
5960 and provided, further, that “medically necessary services” shall include administrative and
5961 processing costs associated with the provision of blood and its derivatives.

5962 “Non-providing employer”, an employer of a state-funded employee, as defined in this
5963 section; provided, however, that the term “non-providing employer” shall not include: (i) an
5964 employer who complies with chapter 151F for such employee; (ii) an employer that is signatory
5965 to or obligated under a negotiated, bona fide collective bargaining agreement between such
5966 employer and bona fide employee representative which agreement governs the employment
5967 conditions of such person receiving free care; (iii) an employer who participates in the insurance
5968 reimbursement program; or (iv) an employer that employs not more than 10 employees;
5969 provided, further, that for the purposes of this definition, an employer shall not be considered to
5970 pay for or arrange for the purchase of health care services provided by acute hospitals and
5971 ambulatory surgical centers by making or arranging for any payments to the uncompensated care
5972 pool.

5973 SECTION 212. Said section 1 of said chapter 176Q, as so appearing, is hereby further
5974 amended by inserting after the definition of “Participating institution” the following definition:-

5975 “Payments from non-providing employers”, all amounts paid to the Uncompensated Care
5976 Trust Fund or the General Fund or any successor fund by non-providing employers.

5977 SECTION 213. Said section 1 of said chapter 176Q is hereby further amended by
5978 inserting after the definition of “Stand-alone vision plan”, inserted by section 39 of chapter 118
5979 of the acts of 2012, the following definition:-

5980 “State-funded employee”, any employed person, or dependent of such person, who
5981 receives, on more than 3 occasions during any hospital fiscal year, health services paid for as free
5982 care; or any employed persons, or dependents of such persons, of a company that has 5 or more
5983 occurrences of health services paid for as free care by all employees in aggregate during any

5984 fiscal year; provided, that an occurrence shall include all healthcare related services incurred
5985 during a single visit to a health care professional.

5986 SECTION 214. Said section 1 of said chapter 176Q, as appearing in the 2010 Official
5987 Edition, is hereby further amended by adding the following definition:-

5988 “Uninsured patient”, a patient who is not covered by a health insurance plan, a self-
5989 insurance health plan or a medical assistance program.

5990 SECTION 215. Said chapter 176Q is hereby further amended by adding the following 2
5991 sections:—

5992 Section 17. (a) The connector shall prepare a form, to be called the employer health
5993 insurance responsibility disclosure, on which an employer shall report whether it is in
5994 compliance with chapter 151F and any other information required by the connector relative to
5995 section 18 and paragraph (4) of subsection (a) of section 69 of chapter 118E. The form shall be
5996 completed, signed and returned to the connector by every employer with 11 or more full-time
5997 equivalent employees.

5998 (b) The connector shall prepare a form, to be called the employee health insurance
5999 responsibility disclosure, on which an employee of employers with 11 or more full-time
6000 equivalent employees who declines an employer-sponsored health plan shall report whether the
6001 employee has an alternative source of health insurance coverage. The form shall be completed
6002 and signed by the employee and shall be retained by the employer for 3 years. The connector
6003 may request a copy of the signed employee form.

6004 (c) Information that identifies individual employees by name or health insurance status
6005 shall not be a public record, but the information shall be exchanged with the department of
6006 revenue, the commonwealth health insurance connector authority and the health care access
6007 bureau in the division of insurance under an interagency services agreement to enforce this
6008 section, sections 3 to 7A, inclusive, and sections 3, 6B and 18B of chapter 118H. An employer
6009 who knowingly falsifies or fails to file with the connector any information required by this
6010 section or by any regulation promulgated by the connector shall be punished by a fine of not less
6011 than \$1,000 and not more than \$5,000.

6012 Section 18. (a) The authority shall, upon verification of the provision of services and
6013 costs to a state-funded employee, assess a free rider surcharge on the non-providing employer
6014 under regulations promulgated by the authority.

6015 (b) The amount of the free rider surcharge on non-providing employers shall be
6016 determined by the authority under regulations promulgated by the authority, and assessed by the
6017 authority not later than 3 months after the end of each hospital fiscal year, with payment by non-
6018 providing employers not later than 180 days after the assessment. The amount charged by the
6019 authority shall be greater than 10 per cent but not greater than 100 per cent of the cost to the state
6020 of the services provided to the state-funded employee, considering all payments received by the
6021 state from other financing sources for free care; provided, that the “cost to the state” for services
6022 provided to any state-funded employee may be determined by the authority as a percentage of
6023 the state’s share of aggregate costs for health services. The free rider surcharge shall only be
6024 triggered upon incurring \$50,000 or more, in any hospital fiscal year, in free care services for
6025 any employer’s employees, or dependents of such persons, in aggregate, regardless of how many
6026 state-funded employees are employed by that employer.

6027 (c) The formula for assessing free rider surcharges on non-providing employers shall be
6028 set forth in regulations promulgated by the authority that shall be based on factors including, but
6029 not limited to: (i) the number of incidents during the past year in which employees of the non-
6030 providing employer received services reimbursed by the health safety net office under section 69
6031 of chapter 118E; (ii) the number of persons employed by the non-providing employer; and (iii)
6032 the proportion of employees for whom the non-providing employer provides health insurance.

6033 (d) If a state-funded employee is employed by more than 1 non-providing employer at the
6034 time the state-funded employee receives services, the authority shall assess a free rider surcharge
6035 on each said employer consistent with the formula established by the authority under this section.

6036 (e) The authority shall specify by regulation appropriate mechanisms for implementing
6037 free rider surcharges on non-providing employers. Said regulations shall include, but not be
6038 limited to, the following provisions: (i) appropriate mechanisms that provide for determination
6039 and payment of the surcharge by a non-providing employer including requirements for data to be
6040 submitted by employers, employees, acute hospitals and ambulatory surgical centers, and other
6041 persons; and (ii) penalties for nonpayment or late payment by the non-providing employer,
6042 including assessment of interest on the unpaid liability at a rate not to exceed an annual
6043 percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per
6044 month.

6045 (f) All surcharge payments made under this section shall be deposited into the
6046 Commonwealth Care Trust Fund, established under section 2000 of chapter 29.

6047 (g) A non-providing employer's liability to the Commonwealth Care Trust Fund shall, in
6048 the case of a transfer of ownership, be assumed by the successor in interest to the non-providing
6049 employer's interest.

6050 (h) If a non-providing employer fails to file any data, statistics or schedules or other
6051 information required under this chapter or by any regulation promulgated by the authority, the
6052 authority shall provide written notice of the required information. If the employer fails to provide
6053 information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject
6054 to a civil penalty of not more than \$5,000 for each week on which such violation occurs or
6055 continues, which penalty may be assessed in an action brought on behalf of the commonwealth
6056 in any court of competent jurisdiction.

6057 (i) The attorney general shall bring any appropriate action, including injunctive relief, as
6058 may be necessary for the enforcement of this chapter.

6059 (j) No employer shall discriminate against any employee on the basis of the employee's
6060 receipt of free care, the employee's reporting or disclosure of the employer's identity and other
6061 information about the employer, the employee's completion of a Health Insurance Responsibility
6062 Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed
6063 against the employer in relation to the employee. Violation of this subsection shall constitute a
6064 per se violation of chapter 93A.

6065 (k) A hospital, surgical center, health center or other entity that provides uncompensated
6066 care pool services shall provide an uninsured patient with written notice of the criminal penalties
6067 for committing fraud in connection with the receipt of uncompensated care pool services. The
6068 authority shall promulgate a standard written notice form to be made available to health care

6069 providers in English and other languages. The form shall further include written notice of every
6070 employee's protection from employment discrimination under this section.

6071 SECTION 216. The General Laws are hereby amended by inserting after chapter 176R
6072 the following 2 chapters:-

6073 CHAPTER 176S

6074 CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

6075 Section 1. As used in this chapter, the following words shall, unless the context clearly
6076 requires otherwise, have the following meanings:-

6077 "Carrier", (1) an insurer licensed or otherwise authorized to transact accident or health
6078 insurance under chapter 175; (2) a nonprofit hospital service corporation organized under chapter
6079 176A; (3) a nonprofit medical service corporation organized under chapter 176B; (4) a health
6080 maintenance organization organized under chapter 176G; (5) an organization entering into a
6081 preferred provider arrangement under chapter 176I; (6) a contributory group general or blanket
6082 insurance for persons in the service of the commonwealth under chapter 32A; (7) a contributory
6083 group general or blanket insurance for persons in the service of counties, cities, towns and
6084 districts, and their dependents under chapter 32B; (8) the medical assistance program
6085 administered by the office of Medicaid pursuant to chapter 118E and in accordance with Title
6086 XIX of the Social Security Act or any successor statute; and (9) any other medical assistance
6087 program operated by a governmental unit for persons categorically eligible for such program.

6088 "Commissioner", the commissioner of insurance.

6089 “Insured”, an enrollee, covered person, insured, member, policyholder or subscriber of a
6090 carrier.

6091 “Nondiscriminatory basis”, a carrier shall be deemed to be providing coverage on a non-
6092 discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service
6093 limitation imposed on coverage for the care provided by a physician assistant which is less than
6094 any annual or lifetime dollar or unit of service limitation imposed on coverage for the same
6095 services by other participating providers.

6096 “Participating provider”, a provider who, under terms and conditions of a contract with
6097 the carrier or with its contractor or subcontractor, has agreed to provide health care services to an
6098 insured with an expectation of receiving payment, other than coinsurance, co-payments or
6099 deductibles, directly or indirectly from the carrier.

6100 “Physician assistant”, a person who is a graduate of an approved program for the training
6101 of physician assistants who is supervised by a registered physician in accordance with sections
6102 9C to 9H, inclusive, of chapter 112, and who has passed the Physician Assistant National
6103 Certifying Exam or its equivalent.

6104 “Primary care provider”, a health care professional qualified to provide general medical
6105 care for common health care problems who (1) supervises, coordinates, prescribes, or otherwise
6106 provides or proposes health care services; (2) initiates referrals for specialist care; and (3)
6107 maintains continuity of care within the scope of practice.

6108 Section 2. The commissioner and the group insurance commission shall require that all
6109 carriers recognize physician assistants as participating providers subject to section 3 and shall
6110 include coverage on a nondiscriminatory basis to their insureds for care provided by physician

6111 assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall
6112 include benefits for primary care, intermediate care and inpatient care, including care provided in
6113 a hospital, clinic, professional office, home care setting, long-term care setting, mental health or
6114 substance abuse program, or any other setting when rendered by a physician assistant who is a
6115 participating provider and is practicing within the scope of his or her professional authority as
6116 defined by statute, rule and physician delegation to the extent that such policy or contract
6117 currently provides benefits for identical services rendered by a provider of health care licensed
6118 by the commonwealth.

6119 Section 3. A participating provider physician assistant practicing within the scope of such
6120 physician assistant's license, including all regulations requiring collaboration with or supervision
6121 by a physician under section 9E of chapter 112, shall be considered qualified within the carrier's
6122 definition of primary care provider to an insured.

6123 Section 4. Notwithstanding any general or special law to the contrary, a carrier that
6124 requires the designation of a primary care provider shall provide its insured with an opportunity
6125 to select a participating provider physician assistant as a primary care provider.

6126 Section 5. Notwithstanding any general or special law to the contrary, a carrier shall
6127 ensure that all participating provider physician assistants are included on any publicly accessible
6128 list of participating providers for the carrier.

6129 Section 6. A complaint for noncompliance against a carrier shall be filed with and
6130 investigated by the commissioner or the group insurance commission, whichever shall have
6131 regulatory authority over the carrier. The commissioner and the group insurance commission
6132 shall promulgate regulations to enforce this chapter.

6133 CHAPTER 176T

6134 RISK-BEARING PROVIDER ORGANIZATIONS

6135 Section 1. As used in this chapter the following words shall, unless the context clearly
6136 requires otherwise, have the following meanings:-

6137 “Alternative payment contract”, any contract between a provider or provider organization
6138 and a health care payer payer which utilizes alternative payment methodologies.

6139 “Alternative payment methodologies or methods”, methods of payment that are not solely
6140 based on fee-for-service reimbursements; provided, however, that “alternative payment
6141 methodologies” may include, but shall not be limited to, shared savings arrangement, bundled
6142 payments, and global payments; and further provided, that “alternative payment methodologies”
6143 may include fee-for-service payments, which are settled or reconciled with a bundled or global
6144 payment.

6145 “Carrier,” an insurer licensed or otherwise authorized to transact accident or health
6146 insurance under chapter 175; a nonprofit hospital service corporation organized under chapter
6147 176A; a nonprofit medical service corporation organized under chapter 176B; a health
6148 maintenance organization organized under chapter 176G; and an organization entering into a
6149 preferred provider arrangement under chapter 176I, but not including an employer purchasing
6150 coverage or acting on behalf of its employees or the employees of 1 or more subsidiaries or
6151 affiliated corporations of the employer; provided, however, that, unless otherwise noted, the term
6152 “carrier” shall not include any entity to the extent it offers a policy, certificate or contract that
6153 provides coverage solely for dental care services or vision care services.

6154 “Center”, the center for health information and analysis established in chapter 12C.

6155 “Commission”, the health policy commission established in chapter 6D.

6156 “Commissioner”, the commissioner of insurance.

6157 “Division”, the division of insurance.

6158 “Downside risk”, the risk taken on by a provider organization as part of an alternate
6159 payment contract with a carrier or other payer in which the provider organization is responsible
6160 for either the full or partial costs of treating a group of patients that may exceed the contracted
6161 budgeted payment arrangements.

6162 “Employer”, an employer as defined in section 1 of chapter 151A.

6163 “Health care services”, supplies, care and services of medical, surgical, optometric,
6164 dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative,
6165 supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital
6166 care and services, provided by a community health center, home health and hospice care
6167 provider, or by a sanatorium, as included in the definition of “hospital” in Title XVIII of the
6168 federal Social Security Act, and treatment and care compatible with such services or by a health
6169 maintenance organization.

6170 “Medicaid program”, the medical assistance program administered by the office of
6171 Medicaid under chapter 118E and in accordance with Title XIX of the Federal Social Security
6172 Act or any successor statute.

6173 “Medical assistance program”, the medicaid program, the Veterans Administration health
6174 and hospital programs and any other medical assistance program operated by a governmental
6175 unit for persons categorically eligible for such program.

6176 “Medical service corporation”, a corporation established to operate a nonprofit medical
6177 service plan as provided in chapter 176B.

6178 “Medicare program”, the medical insurance program established by Title XVIII of the
6179 Social Security Act.

6180 “Provider” or “health care provider”, any person, corporation, partnership, governmental
6181 unit, state institution or any other entity qualified under the laws of the commonwealth to
6182 perform or provide health care services.

6183 “Provider organization”, any corporation, partnership, business trust, association or
6184 organized group of persons in the business of health care delivery or management whether
6185 incorporated or not that represents 1 or more health care providers in contracting with carriers for
6186 the payments of health care services; provided, however, that “provider organization” shall
6187 include, but not be limited to, physician organizations, physician-hospital organizations,
6188 independent practice associations, provider networks, accountable care organizations and any
6189 other organization that contracts with carriers for payment for health care services.

6190 “Public health care payer”, the Medicaid program established in chapter 118E; any
6191 carrier or other entity that contracts with the office of Medicaid or the commonwealth health
6192 insurance connector to pay for or arrange the purchase of health care services on behalf of
6193 individuals enrolled in health coverage programs under Titles XIX or XXI, or under the
6194 commonwealth care health insurance program, including prepaid health plans subject to the

6195 provisions of section 28 of chapter 47 of the acts of 1997; the group insurance commission
6196 established under chapter 32A; and any city or town with a population of more than 60,000 that
6197 has adopted chapter 32B.

6198 “Registered provider organization”, a provider organization that has been registered in
6199 accordance with chapter 6D.

6200 “Risk-bearing provider organization”, a provider organization that manages the treatment
6201 of a group of patients and bears the downside risk according to the terms of an alternate payment
6202 contract.

6203 “Risk certificate”, a certificate of solvency issued by the division of insurance.

6204 “Self-insurance health plan”, a plan which provides health benefits to the employees of a
6205 business, which is not a health insurance plan, and in which the business is liable for the actual
6206 costs of the health care services provided by the plan and administrative costs.

6207 “Title XIX,” Title XIX of the Social Security Act, 42 USC 1396 et seq., or any successor
6208 statute enacted for the same purposes as Title XIX.

6209 Section 2. Except as hereinafter provided, a risk-bearing provider organization shall not
6210 be subject to chapters 175, 176A, 176B, 176C, 176E, 176F, 176G and 176J; provided, however,
6211 that a risk-bearing provider organization that enters into a contract with employers or individuals
6212 under which the provider organization would assume a significant portion of downside risk, as
6213 defined through division regulations, may be subject to the provisions of said chapters 175,
6214 176A, 176B, 176C, 176E, 176F, 176G and 176J for the purposes of such contracts.

6215 Section 3. (a) Each registered provider organization that enters into or renews an
6216 alternative payment contract with a carrier or public health care payer in which the provider
6217 organization accepts downside risk shall file an application for a risk certificate with the division;
6218 provided, however, that integrated care organizations or senior care organizations contracted
6219 under section 9D or 9E of chapter 118E which have undergone a financial solvency certification
6220 shall be deemed to be to have satisfied the risk certificate requirements for purposes of this
6221 chapter.

6222 (b) A risk-bearing provider organization may apply for a risk certificate waiver if it
6223 wishes to demonstrate that its alternative payment contracts do not contain significant downside
6224 risk. A risk-bearing provider organization may be deemed to be in compliance with the
6225 division's standards if the division determines that the provider organization's alternative
6226 payment contracts do not contain significant downside risk. The division shall forward such
6227 waiver in writing to the commission and the center.

6228 (c) The applicant for a risk certificate shall file such information as the commissioner
6229 shall by regulation require, in a form approved by the commissioner. A risk-bearing provider
6230 organization shall make an annual filing to renew its risk certificate. Such information shall
6231 include, but not be limited to:

6232 (1) the filing materials submitted to be registered as a provider organization, pursuant to
6233 chapter 6D;

6234 (2) a list of all carriers and public health payers with which the provider organization has
6235 entered into alternative payment contracts with downside risk;

6236 (3) financial statements showing the risk-bearing provider organization's assets,
6237 liabilities, reserves and sources of working capital and other sources of financial support and
6238 projections of the results of operations for the succeeding 3 years;

6239 (4) a financial plan, including a statement indicating the anticipated timing for
6240 receipt of income from alternative payment contracts with downside risk versus the incurrence
6241 of expenses, a statement of the applicant's plan to establish and maintain sufficient reserves or
6242 other resources that will protect the risk-bearing provider organization from the potential losses
6243 from downside risk, copies of insurance or other agreements which protect the risk-bearing
6244 provider organization from potential losses from downside risk, and a detailed description of
6245 mechanisms to monitor the financial solvency of any provider organization subcontracting with
6246 the applicant that assumes downside risk in its alternative payment arrangement with the risk-
6247 bearing provider organization;

6248 (5) a utilization plan describing the methods by which the risk-bearing provider
6249 organization will monitor inpatient and outpatient utilization under the alternative payment
6250 contracts with downside risk;

6251 (6) an actuarial certification that, after examining the terms of all the risk-bearing
6252 provider organization's alternative payment contracts with downside risk that the alternate
6253 payment contracts are not expected to threaten the financial solvency of the risk-bearing provider
6254 organization; and

6255 (7) such other information as the division may specify through regulation.

6256 (d) There shall be a fee for such application or renewal, in an amount determined by the
6257 commissioner.

6258 (e) A risk-bearing provider organization shall notify the commissioner of any material
6259 change to the information submitted in its initial or renewal application, in a form approved by
6260 the commissioner.

6261 Section 4. (a) The commissioner may make an examination of the affairs of a risk-
6262 bearing provider organization regarding its alternate payment arrangements with downside risk
6263 when the commissioner deems prudent but, not less frequently than once every 3 years. The
6264 focus of the examination shall be to ensure that a risk-bearing provider organization is not
6265 subject to adverse conditions which in the commissioner's determination have at least a
6266 moderate potential to impact a risk-bearing entity's ability to meet its risk-bearing
6267 responsibilities under any alternative payment contracts. The examination shall be conducted
6268 according to the procedures set forth in subsection (6) of section 4 of chapter 175.

6269 (b) The commissioner, a deputy or an examiner may conduct an on-site examination of
6270 each risk-bearing provider organization in the commonwealth to thoroughly inspect and examine
6271 its affairs and ascertain its financial condition in the context of its ability to fulfill its risk-bearing
6272 obligations.

6273 (c) The charge for each such examination shall be determined annually according to the
6274 procedures set forth in subsection (6) of section 4 of chapter 175.

6275 (d) The assets and liabilities of the risk-bearing provider organization shall be allowed
6276 and computed, in any report of an examination under this section, in accordance with generally
6277 accepted accounting principles or as the commissioner may otherwise deem appropriate.

6278 (e) No later than 60 days following completion of the examination, the examiner in
6279 charge shall file with the commissioner a verified written report of examination under oath.

6280 Upon receipt of the verified report, the commissioner shall transmit the report to the risk-bearing
6281 provider organization examined together with a notice which shall afford the risk-bearing
6282 provider organization examined a reasonable opportunity of not more than 30 days to make a
6283 written submission or rebuttal with respect to any matters contained in the examination report.
6284 Within 30 days of the end of the period allowed for the receipt of written submissions or
6285 rebuttals, the commissioner shall consider and review the reports together with any written
6286 submissions or rebuttals and any relevant portions of the examiner's work papers and enter an
6287 order:

6288 (i) adopting the examination report as filed with modifications or corrections and,
6289 if the examination report reveals that the risk-bearing provider organization is operating in
6290 violation of this section or any regulation or prior order of the commissioner, the commissioner
6291 may order the risk-bearing provider organization to take any action the commissioner considered
6292 necessary and appropriate to cure such violation;

6293 (ii) rejecting the examination report with directions to examiners to reopen the
6294 examination for the purposes of obtaining additional data, documentation or information and re-
6295 filing pursuant to the above provisions; or

6296 (iii) calling for an investigatory hearing with no less than 20 days notice to the
6297 risk-bearing provider organization for purposes of obtaining additional documentation, data,
6298 information and testimony.

6299 (f) Notwithstanding any other General Law to the contrary, including clause Twenty-
6300 sixth of section 7 of chapter 4 and chapter 66, the records of any such audit, examination or other
6301 inspection and the information contained in the records, reports or books of any risk-bearing

6302 provider organization examined pursuant to this section shall be confidential and open only to
6303 the inspection of the commissioner, or the examiners and assistants. Access to such confidential
6304 material may be granted by the commissioner to law enforcement officials of the commonwealth
6305 or any other state or agency of the federal government at any time, so long as the agency or
6306 office receiving the information agrees in writing to hold such material confidential. Nothing
6307 herein shall be construed to prohibit the required production of such records, and information
6308 contained in the reports of such company or organization before any court of the commonwealth
6309 or any master or auditor appointed by any such court, in any criminal or civil proceeding,
6310 affecting such risk-bearing provider organization, its officers, partners, directors or employees.
6311 The final report of any such audit, examination or any other inspection by or on behalf of the
6312 division of insurance shall be a public record.

6313 Section 5. (a) If upon examination or at any other time the commissioner determines that
6314 the risk-bearing provider organization's existing or proposed alternative payment contracts with
6315 downside risk are likely to threaten the financial solvency of the risk-bearing provider
6316 organization, the commissioner shall provide notice to the risk-bearing provider organization.

6317 (b) The commissioner may suspend, cancel, non-renew or refuse to issue a risk-bearing
6318 provider organization's risk certificate upon a determination that the risk-bearing provider
6319 organization has not cured a threat to financial solvency, that the risk-bearing provider
6320 organization's application for a risk certificate is incomplete or contains or is based on fraudulent
6321 information, or that the risk-bearing provider organization has otherwise failed to comply with
6322 the requirements of this chapter. The commissioner shall notify the risk-bearing provider
6323 organization and advise, in writing, of the reason for any refusal to issue or non-renew a risk
6324 certificate under this chapter. A copy of the notice shall be forwarded to the commission and

6325 center. The applicant or certified risk-bearing provider organization may make written demand
6326 upon the commissioner within 30 days of receipt of such notification for a hearing before the
6327 commissioner to determine the reasonableness of the commissioner's action. The hearing shall
6328 be held pursuant to chapter 30A.

6329 (c) The commissioner shall not suspend or cancel a risk certificate unless the
6330 commissioner has first afforded the risk-bearing provider organization an opportunity for a
6331 hearing pursuant to chapter 30A.

6332 (d) Upon a ruling by the commissioner to suspend or cancel a risk-bearing provider
6333 organization's certification, a written notice shall be forwarded to the commission and the center.

6334 Section 6. (a) For purposes of this section, "health care provider" shall mean any
6335 physician, hospital or other person or entity furnishing health services that has contracted to
6336 provide services according to its agreements with a risk-bearing provider organization.

6337 (b) A health care provider or any representative of a health care provider shall not
6338 maintain any action against a patient to collect or attempt to collect any money owed to the
6339 health care provider by a risk-bearing provider organization.

6340 (c) A risk-bearing provider organization shall include provisions within its contracts with
6341 health care providers that conspicuously prohibit health care providers from collecting or
6342 attempting to collect money from a patient that is owed to the health care provider by a risk-
6343 bearing provider organization.

6344 Section 7. All information provided by risk-bearing provider organizations to the
6345 division under this chapter shall be made available to the center and the commission.

6346 Section 8. Nothing in this chapter shall exempt any person from any applicable
6347 provisions of chapter 111, 112 or 176T including, but not limited to, provisions relating to
6348 determination of need, licensure and regulation of hospitals and clinics and registration of health
6349 professionals.

6350 Section 9. The commissioner shall promulgate rules and regulations as are necessary to
6351 carry out the provisions of this chapter. In developing the rules and regulations, including risk-
6352 bearing standards, certification and reporting requirements, the commissioner shall consider
6353 other rules and regulations applicable to such organizations and shall consult with the center and
6354 the commission regarding standards concerning provider organizations which enter into
6355 alternative payment contracts.

6356 SECTION 218. Section 8A of chapter 180 of the General Laws, as appearing in the 2010
6357 Official Edition, is hereby amended by striking out, in lines 100 and 101, the words “division of
6358 health care finance and policy pursuant to chapter 118G” and inserting in place thereof the
6359 following words:- center for health information and analysis under chapter 12C.

6360 SECTION 219. Section 9 of chapter 209C of the General Laws is hereby amended by
6361 striking out, in lines 36 and 37, as so appearing, the words “the division of medical assistance or
6362 division of health care finance and policy” and inserting in place thereof the following words:-
6363 the office of Medicaid or the executive office of health and human services.

6364 SECTION 220. Section 60K of chapter 231 of the General Laws, as so appearing, is
6365 hereby amended by striking out, in line 14, the figure “4” and inserting in place thereof the
6366 following figure:- 2.

6367 SECTION 221. Said chapter 231 is hereby further amended by inserting after section
6368 60K the following section:-

6369 Section 60L. (a) Except as otherwise provided in this section, a person shall not
6370 commence an action against a provider of health care as defined in the seventh paragraph of
6371 section 60B unless the person has given the health care provider 182 days written notice before
6372 the action is commenced.

6373 (b) The notice of intent to file a claim required under subsection (a) shall be mailed to the
6374 last known professional business address or residential address of the health care provider who is
6375 the subject of the claim.

6376 (c) The 182-day notice period in subsection (a) shall be shortened to 90 days if:

6377 (1) the claimant has previously filed the 182-day notice required against another
6378 health care provider involved in the claim; or

6379 (2) the claimant has filed a complaint and commenced an action alleging medical
6380 malpractice against any health care provider involved in the claim.

6381 (d) The 182 day notice of intent required in subsection (a) shall not be required if the
6382 claimant did not identify and could not reasonably have identified a health care provider to
6383 which notice shall be sent as a potential party to the action before filing the complaint;

6384 (e) The notice given to a health care provider under this section shall contain, but shall
6385 not be limited to, a statement including:

6386 (1) the factual basis for the claim;

6387 (2) the applicable standard of care alleged by the claimant;

6388 (3) the manner in which it is claimed that the applicable standard of care was
6389 breached by the health care provider;

6390 (4) the alleged action that should have been taken to achieve compliance with the
6391 alleged standard of care;

6392 (5) the manner in which it is alleged the breach of the standard of care was the
6393 proximate cause of the injury claimed in the notice; and

6394 (6) the names of all health care providers that the claimant intends to notify under
6395 this section in relation to a claim.

6396 (f) Not later than 56 days after giving notice under this section, the claimant shall allow
6397 the health care provider receiving the notice access to all of the medical records related to the
6398 claim that are in the claimant's control and shall furnish a release for any medical records related
6399 to the claim that are not in the claimant's control, but of which the claimant has knowledge.

6400 This subsection shall not restrict a patient's right of access to the patient's medical records under
6401 any other law.

6402 (g) Within 150 days after receipt of notice under this section, the health care provider or
6403 authorized representative against whom the claim is made shall furnish to the claimant or the
6404 claimant's authorized representative a written response that contains a statement including the
6405 following:

6406 (1) the factual basis for the defense, if any, to the claim;

6407 (2) the standard of care that the health care provider claims to be applicable to the
6408 action;

6409 (3) the manner in which it is claimed by the health care provider that there was or
6410 was not compliance with the applicable standard of care; and

6411 (4) the manner in which the health care provider contends that the alleged
6412 negligence of the health care provider was or was not a proximate cause of the claimant's alleged
6413 injury or alleged damage.

6414 (h) If the claimant does not receive the written response required under subsection (g)
6415 within the required 150-day time period, the claimant may commence an action alleging medical
6416 malpractice upon the expiration of the 150-day time period. If a provider fails to respond within
6417 150 days and that fact is made known to the court in the plaintiffs' complaint or by any other
6418 means then interest on any judgment against that provider shall accrue and be calculated from
6419 the date that the notice was filed rather than the date that the suit is filed. At any time before the
6420 expiration of the 150-day period, the claimant and the provider may agree to an extension of the
6421 150-day period.

6422 (i) If at any time during the applicable notice period under this section a health care
6423 provider receiving notice under this section informs the claimant in writing that the health care
6424 provider does not intend to settle the claim within the applicable notice period, the claimant may
6425 commence an action alleging medical malpractice against the health care provider, so long as the
6426 claim is not barred by the statutes of limitations or repose.

6427 (j) A lawsuit against a health care provider filed within 6 months of the statute of
6428 limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any
6429 claimant, shall be exempt from compliance with this section.

6430 (k) Nothing in this section shall prohibit the filing of suit at any time in order to seek
6431 court orders to preserve and permit inspection of tangible evidence.

6432 SECTION 222. Section 85K of said chapter 231, as appearing in the 2010 Official
6433 Edition, is hereby amended by inserting after the word “costs”, in line 8, the following words:- ;
6434 and provided further, that in the context of medical malpractice claims against a nonprofit
6435 organization providing health care, such cause of action shall not exceed the sum of \$100,000,
6436 exclusive of interest and costs.

6437 SECTION 223. Chapter 233 of the General Laws is hereby amended by inserting after
6438 section 79K the following section:-

6439 Section 79L. (a) As used in this section, the following words shall, unless the context
6440 clearly requires otherwise, have the following meanings:

6441 “Facility”, a hospital, clinic, or nursing home licensed under chapter 111, a psychiatric
6442 facility licensed under chapter 19 or a home health agency; provided, however, that “facility”
6443 shall also include any corporation, professional corporation, partnership, limited liability
6444 company, limited liability partnership, authority or other entity comprised of such facilities.

6445 “Health care provider”, any of the following health care professionals licensed under
6446 chapter 112: a physician, podiatrist, physical therapist, occupational therapist, dentist, dental
6447 hygienist, optometrist, nurse, nurse practitioner, physician assistant, chiropractor, psychologist,

6448 independent clinical social worker, speech-language pathologist, audiologist, marriage and
6449 family therapist or mental health counselor; provided, however, that “health care provider” shall
6450 also include any corporation, professional corporation, partnership, limited liability company,
6451 limited liability partnership, authority, or other entity comprised of such health care providers.

6452 “Unanticipated outcome”, the outcome of a medical treatment or procedure, whether or
6453 not resulting from an intentional act, that differs from an intended result of such medical
6454 treatment or procedure.

6455 (b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly
6456 experiencing an unanticipated outcome of medical care, all statements, affirmations, gestures,
6457 activities or conduct expressing benevolence, regret, apology, sympathy, commiseration,
6458 condolence, compassion, mistake, error or a general sense of concern which are made by a health
6459 care provider, facility or an employee or agent of a health care provider or facility, to the patient,
6460 a relative of the patient or a representative of the patient and which relate to the unanticipated
6461 outcome shall be inadmissible as evidence in any judicial or administrative proceeding, unless
6462 the maker of the statement, or a defense expert witness, when questioned under oath during the
6463 litigation about facts and opinions regarding any mistakes or errors that occurred, makes a
6464 contradictory or inconsistent statement as to material facts or opinions, in which case the
6465 statements and opinions made about the mistake or error shall be admissible for all purposes. In
6466 situations where a patient suffers an unanticipated outcome with significant medical
6467 complication resulting from the provider’s mistake, the health care provider, facility or an
6468 employee or agent of a health care provider or facility shall fully inform the patient and, when
6469 appropriate, the patient's family, about said unanticipated outcome.

6470 SECTION 224. Clause (2) of subsection (b) of section 3 of chapter 258C of the General
6471 Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out subclause (A)
6472 and inserting in place thereof the following subclause:-

6473 (A) Expenses incurred for hospital services as the direct result of injury to the victim
6474 shall be compensable under this chapter; provided, however, that when claiming compensation
6475 for hospital expenses, the claimant shall demonstrate an out-of-pocket loss or a legal liability for
6476 payment of said expenses. No hospital expenses shall be paid if the expense is reimbursable by
6477 Medicaid or if the services are covered by chapter 118E. Every claim for compensation for
6478 hospital services shall include a certification by the hospital that the services are not
6479 reimbursable by Medicaid and that the services are not covered by chapter 118E. In no event
6480 shall the amounts awarded for hospital services exceed the rates for services established by the
6481 executive office of health and human services or a governmental unit designated by the executive
6482 office if rates have been established for such services.

6483 SECTION 225. Section 62 of chapter 177 of the acts of 2001 is hereby amended by
6484 inserting after the word “commission”, in line 2, the following words: - , the executive director
6485 of the commonwealth health insurance connector authority.

6486 SECTION 226. The first paragraph of section 271 of chapter 127 of the acts of 1999 is
6487 hereby amended by inserting after the word “affairs”, in line 3, the following words:- , the
6488 executive director of the commonwealth health insurance connector authority.

6489 SECTION 227. Said first paragraph of said section 271 of said chapter 127 is hereby
6490 further amended by striking out clause (i) and inserting in place thereof the following words:- (i)
6491 enrollees in Commonwealth Care under chapter 176Q of the General Laws.

6492 SECTION 228. Section 16 of chapter 257 of the acts of 2008, as amended by section 27
6493 of chapter 9 of the acts of 2011, is hereby further amended by striking out the words “section 7
6494 of chapter 118G” and inserting in place thereof the following words:- section 13D of chapter
6495 118E.

6496 SECTION 229. Section 17 of said chapter 257, as most recently amended by section 28
6497 of said chapter 9 of the acts of 2011, is hereby amended by striking out the words “7 of chapter
6498 118G” and inserting in place thereof the following words:- 13D of chapter 118E.

6499 SECTION 230. Section 18 of said chapter 257, as amended by section 29 of said chapter
6500 9, is hereby further amended by striking out the words “section 7 of chapter 118G” and inserting
6501 in place thereof the following words:- “section 13D of chapter 118E.

6502 SECTION 231. Section 15 of chapter 305 of the acts of 2008 is hereby repealed.

6503 SECTION 232. Section 31 of chapter 288 of the acts of 2010 is hereby repealed.

6504 SECTION 233. Section 54 of said chapter 288 is hereby repealed.

6505 SECTION 234. Said chapter 288 is hereby further amended by striking out section 66
6506 and inserting in place thereof the following section:—

6507 Section 66. For small group base rate factors applied under section 3 of chapter 176J of
6508 the General Laws between October 1, 2010 and July 1, 2015, a carrier shall limit the effect of the
6509 application of any single or combination of rate adjustment factors identified in clauses (2) to (6),
6510 inclusive, of subsection (a) of said chapter 3 of said chapter 176J that are used in the calculation
6511 of an individual’s or small group’s premium so that the final annual premium charged to an

6512 individual or small group does not increase by more than an amount established annually by the
6513 commissioner by regulation.

6514 SECTION 235. Section 70 of said chapter 288 is hereby repealed.

6515 SECTION 236. The first sentence of section 48 of chapter 9 of the acts of 2011 is hereby
6516 amended by striking out the words “7 of chapter 118G” and inserting in place thereof the
6517 following words:- 13D of chapter 118E.

6518 SECTION 237. Notwithstanding any general or special law to the contrary, no provision
6519 of this act shall be construed to impair or in any way modify the authority of the executive office
6520 of health and human services to act, pursuant to section 16 of chapter 6A of the General Laws, as
6521 the single state agency authorized to supervise and administer the state programs under titles
6522 XIX and XXI of the Social Security Act.

6523 SECTION 238. The commissioner of revenue, in consultation with the department of
6524 public health and the office of commonwealth performance, accountability and transparency,
6525 shall review the wellness program tax credit in section 6N of chapter 62 of the General Laws and
6526 section 38FF of chapter 63 of the General Laws and report on whether this tax credit achieved
6527 the desired outcome and stated public policy purpose of the tax credit and if the tax credit is the
6528 most cost effective means of achieving this public policy purpose and whether the tax credit
6529 should be subject to a recapture if certain conditions are not met. The commissioner shall file a
6530 report, together with any recommendations regarding whether there should be legislative changes
6531 to the tax credit or whether the goals of the tax credit can better be served through other means,
6532 to the governor and to the clerks of the house and senate who shall forward the same to the joint

6533 committee on revenue, the joint committee on health care financing, and the house and senate
6534 ways and means committees not later than January 1, 2017.

6535 SECTION 239. Notwithstanding any general or special law to the contrary, the
6536 commissioner of revenue, in consultation with the department of public health, shall authorize
6537 annually an amount not to exceed \$15,000,000 for the wellness program tax credit in section 6N
6538 of chapter 62 of the General Laws together with chapter 38FF of chapter 63 of the General Laws.

6539 SECTION 240. (a) The health information technology council, established in section 2
6540 of chapter 118I of the General laws, shall conduct an evaluation of the effectiveness of its
6541 expenditures under section 10 of said chapter 118I, and the Massachusetts e-health institute shall
6542 conduct an evaluation of the effectiveness of expenditures authorized under section 6D of
6543 chapter 40J of the General Laws and each shall submit a report thereon.

6544 (b) The reports by the council and the institute shall include an analysis of all relevant
6545 data so as to determine the effectiveness and return on investment of funding under section 6D of
6546 said chapter 40J and section 10 of chapter 118I. The reviews by the council and the institute shall
6547 each include specific findings and legislative recommendations including the following:-

6548 (1) to what extent their respective programs increased the adoption of
6549 interoperable electronic health records, including to what extent those programs increased the
6550 adoption of interoperable electronic health records for providers;

6551 (2) to what extent their respective programs reduced health care costs or the
6552 growth in health care cost trends on a provider-based net cost and health plan based premium
6553 basis, including an analysis of what entities benefitted from, or were disadvantaged by, any cost
6554 reductions and the specific impact of the funding mechanism;

6555 (3) to what extent their respective programs increased the number of health care
6556 providers in achieving and maintaining compliance with the standards for meaningful use,
6557 beyond stage 1, established by the United States Department of Health and Human Services;

6558 (4) to what extent their respective programs should be discontinued, amended or
6559 expanded and, if so, a timetable for implementation of the recommendations; and

6560 (5) to what extent additional public funding is needed for the implementation of
6561 their respective programs.

6562 (c) To the extent possible, the council and the institute shall obtain and use actual health
6563 plan data from the all-payer claims database as administered by the center for health information
6564 and analysis, but such data shall be confidential and shall not be a public record for any purpose.

6565 (d) The council and the institute shall report the results of their reviews and
6566 recommendations, if any, together with drafts of legislation necessary to carry out such
6567 recommendations by March 31, 2016. The report shall be provided to the chairs of the house
6568 and senate committees on ways and means and the chairs of the joint committee on health care
6569 financing and shall be posted on the council's and the institute's websites.

6570 SECTION 241. (a). Notwithstanding any special or general law to the contrary, the
6571 health policy commission shall establish a one-time surcharge assessment on all acute hospitals
6572 satisfying the requirements of subsection (b) to be deposited according to the requirements of
6573 subsection (f). The surcharge amount to be paid by each acute hospital shall equal the product
6574 of: (i) the surcharge percentage; and (ii) \$60,000,000. The commission shall calculate the
6575 surcharge percentage by dividing the operating surplus in fiscal year 2010 by the total operating
6576 surplus in fiscal year 2010 of all acute hospitals paying an assessment under this section. The

6577 commission shall determine the surcharge percentage for the assessment by December 31, 2012.
6578 In the determination of the surcharge percentage, the commission shall use the best data
6579 available as determined by the commission and may consider the effect on projected surcharge
6580 payments of any modified or waived enforcement pursuant to subsection (c). The commission
6581 shall incorporate all adjustments, including, but not limited to, updates or corrections or final
6582 settlement amounts, by prospective adjustment rather than by retrospective payments or
6583 assessments.

6584 (b) Only acute hospitals or acute hospital systems with more than \$1,000,000,000 in total
6585 net assets and less than 50 per cent of revenues from public payers shall be subject to the
6586 assessment. The commission may waive the assessment for certain acute hospitals, if the
6587 commission reasonably determines the hospital or hospital system lacks access to resources
6588 available to pay the assessment. The commission shall make a determination for waiver based
6589 on the following factors: (A) cash and investments on hand; (B) total revenues; (C) total cash and
6590 investments; (D) total reserves; (E) total profits, margins or surplus; (F) earnings before interest,
6591 depreciation and amortization; (G) administrative expense ratio; and (H) the compensation of
6592 executive managers and board members.

6593 (c) The commission may provide assessment mitigation up to 66 per cent of the surcharge
6594 assessment if an assessable provider meets either of the following:

6595 (1) any acute hospital or acute hospital system that receives more than 25 per cent
6596 of its reimbursements from Title XIX of the Social Security Act; or

6597 (2) any acute hospital or acute hospital system whose net assets do not exceed
6598 \$1,250,000,000.

6599 (d) Surcharge payors shall be assessed a surcharge to be paid to the commission in
6600 accordance with the provisions of subsection (e). The surcharge amount shall equal the product
6601 of: (i) the surcharge percentage; and (ii) \$165,000,000. The commission shall calculate the
6602 surcharge percentage by dividing the surcharge payor's payments for acute hospital services by
6603 the total payments for acute hospital services by all surcharge payors. The commission shall
6604 determine the surcharge percentage for the assessment by December 31, 2012. In the
6605 determination of the surcharge percentage, the commission shall use the best data available as
6606 determined by the commission and may consider the effect on projected surcharge payments of
6607 any modified or waived enforcement pursuant to subsection (c). The commission shall
6608 incorporate all adjustments, including, but not limited to, updates or corrections or final
6609 settlement amounts, by prospective adjustment rather than by retrospective payments or
6610 assessments.

6611 (e) Acute hospitals and surcharge payors shall pay the full amount of the surcharge
6612 amount as follows:

6613 (1) a single payment to be made no later than June 30, 2013; or

6614 (2) in 4 equal annual installments to be paid on or before June 30 of each year beginning on
6615 June 30, 2013.

6616 (f) The assessment shall be distributed as follows by the comptroller as such assessments
6617 are collected:

6618 (1) 60 per cent, for a 4-year a total of \$135,000,000 to the Distressed Hospital Trust Fund,
6619 established in section 2GGGG of chapter 29 of the General Laws; provided, however, that any
6620 reduced assessment under subsections (b) or (c) shall reduce this amount;

6621 (2) 26 and 2/3 per cent, for a 4-year total of \$60,000,000, to the Prevention and Wellness
6622 Trust Fund, established in section 2G of chapter 111 of the General Laws; and

6623 (3) 13 and 1/3 per cent, for a 4-year total of \$30,000,000 to the e-Health Institute Fund
6624 established in section 6E of chapter 40J.

6625 Prior to depositing the assessment in these funds, the comptroller shall deduct 5 per cent of each
6626 amount set forth in this subsection and transfer it to the Health Care Payment Reform Fund
6627 established in section 100 of chapter 194 of the acts of 2011 for the administration of the health
6628 policy commission.

6629 Deposits to the Prevention and Wellness Trust Fund and the e-Health Institute Fund shall
6630 not be reduced due to any waiver authorized by the commission under subsections (b) or (c).
6631 The total amount waived shall be reduced from the amount to be deposited in the Distressed
6632 Hospital Trust Fund.

6633 (g) The commission shall specify by regulation appropriate mechanisms that provide for
6634 determination and payment of an acute hospital, or a surcharge payor's liability, including
6635 requirements for data to be submitted by acute hospitals and surcharge payors.

6636 (h) A hospital's liability to the fund shall in the case of a transfer of ownership be
6637 assumed by the successor in interest to the hospital.

6638 (i) A surcharge payor's liability to the fund shall in the case of a transfer of ownership be
6639 assumed by the successor in interest to the surcharge payor.

6640 (j) The commission shall establish by regulation an appropriate mechanism for enforcing
6641 an acute hospital or surcharge payor's liability to the fund if an acute hospital or surcharge payor

6642 does not make a scheduled payment to the fund; provided, however, that the commission may,
6643 for the purpose of administrative simplicity, establish threshold liability amounts below which
6644 enforcement may be modified or waived. Such enforcement mechanism may include assessment
6645 of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent
6646 and late fees or penalties at a rate not to exceed 5 per cent per month. Such enforcement
6647 mechanism may also include notification to the office of Medicaid requiring an offset of
6648 payments on the claims of the acute hospital or surcharge payor, any entity under common
6649 ownership or any successor in interest to the acute hospital or surcharge payor, from the office of
6650 Medicaid in the amount of payment owed to the fund, including any interest and penalties, and to
6651 transfer the withheld funds into said fund. If the office of Medicaid offsets claims payments as
6652 ordered by the commission, the office of Medicaid shall be considered not to be in breach of
6653 contract or any other obligation for payment of non-contracted services, and an acute hospital or
6654 surcharge payor whose payment is offset under an order of the commission shall serve all Title
6655 XIX recipients under the contract then in effect with the executive office of health and human
6656 services. In no event shall the commission direct the office of Medicaid to offset claims unless
6657 the acute hospital or surcharge payor has maintained an outstanding liability to the fund for a
6658 period longer than 45 days and has received proper notice that the commission intends to initiate
6659 enforcement actions under regulations promulgated by the commission.

6660 (k) If an acute hospital or surcharge payor fails to file any data, statistics or schedules or
6661 other information required under this chapter or by any regulation promulgated by the
6662 commission, the commission shall provide written notice to the acute hospital or surcharge
6663 payor. If an acute hospital or surcharge payor fails to provide required information within 14
6664 days after the receipt of written notice, or falsifies the same, such hospital or payor shall be

6665 subject to a civil penalty of not more than \$5,000 for each day on which the violation occurs or
6666 continues, which penalty may be assessed in an action brought on behalf of the commonwealth
6667 in any court of competent jurisdiction. The attorney general shall bring any appropriate action,
6668 including injunctive relief, necessary for the enforcement of this chapter.

6669 (l) Acute hospitals shall not seek an increase in rates to pay for this assessment.

6670 (m) Surcharge payors shall not seek an increase in premiums to pay for this assessment.

6671 SECTION 242. Notwithstanding any general or special law to the contrary, to the extent
6672 permitted by federal law, every third-party administrator shall disclose to their self-insured or
6673 self-funded employer group health plan clients the contracted prices of services of in-network
6674 providers.

6675 SECTION 243. Any provider organization certified as an accountable care organization
6676 or a patient-centered medical home under chapter 6D of the General Laws and any risk-bearing
6677 provider organization shall have an interoperable electronic medical record system available for
6678 participants to coordinate care, share information and prescribe electronically by December 31,
6679 2016.

6680 SECTION 244. Notwithstanding any general or special law or rule or regulation to the
6681 contrary, the health care workforce center shall investigate the possibility of dedicating funds for
6682 joint appointments for clinicians with clinical agencies and universities. As part of the
6683 arrangement, clinicians pursuing doctoral education would receive tuition and fee reimbursement
6684 for maintaining a clinical position and teaching at the entry level of the academic program while
6685 pursuing their doctoral degree.

6686 SECTION 245. Notwithstanding any general or special law to the contrary, the executive
6687 office of health and human services shall seek from the secretary of the United States
6688 Department of Health and Human Services an exemption or waiver from the Medicare
6689 requirement set forth in 42 U.S.C. §1395x(i) that an admission to a skilled nursing facility be
6690 preceded by a 3-day hospital stay.

6691 SECTION 246. Notwithstanding any general or special law to the contrary, the office of
6692 Medicaid shall not terminate the coverage of any commonwealth care recipient, if: the office has
6693 requested documentation, including the eligibility review form; the recipient has provided such
6694 documentation on or before the date the office stated, in writing, that such documentation was to
6695 be submitted; and the office has acknowledged receipt of the documentation, until the office
6696 determines the eligibility for benefits based on the submitted information. The director of the
6697 office of Medicaid shall promulgate regulations to ensure the proper implementation of this
6698 section.

6699 SECTION 247. The secretary of administration and finance and the secretary of health
6700 and human services shall evaluate the feasibility of contracting for recycling durable medical
6701 equipment purchased and issued by the commonwealth through any and all of its medical
6702 assistance programs.

6703 Said evaluation shall include, but not be limited to, a request for qualifications or
6704 proposals from entities capable of developing, implementing and operating a system of recycling
6705 whereby an inventory of such equipment is developed and managed so as to maximize the
6706 quality of service delivery to equipment recipients and to minimize costs and losses attributable
6707 to waste, fraud or abuse.

6708 The secretary of administration and finance shall report the findings of the evaluation,
6709 together with cost estimates for the operation of a recycling program, estimates of the savings it
6710 would generate and legislative recommendation to the clerks of the house of representatives and
6711 the senate, one joint committee on health care financing, the house committee on ways and
6712 means and the senate committee on ways and means, not later than October 31, 2013.

6713 SECTION 248. Notwithstanding any general or special law to the contrary, the office of
6714 Medicaid and the department of unemployment assistance shall, in consultation with the
6715 executive office of health and human services, develop and implement a means by which the
6716 office of Medicaid may access information as to the status of or termination of unemployment
6717 benefits and the associated insurance coverage by the medical security plan, as administered by
6718 the executive office of labor and workforce development, for the purposes of determining
6719 eligibility for those individuals applying for benefits through health care insurance programs
6720 administered by the executive office of health and human services. The office and the
6721 department shall implement this system not later than February 1, 2013; provided, however, that
6722 if legislative action is required prior to implementation, recommendations for such action shall
6723 be filed with the clerks of the house of representatives and the senate and the joint committee on
6724 health care financing not later than January 1, 2013.

6725 SECTION 249. Notwithstanding any general or special law to the contrary, the division
6726 of insurance, in consultation with the board of registration in medicine, shall conduct a report on
6727 the potential for out-of-state physicians to practice telemedicine in the commonwealth. The
6728 report shall review the following: (i) licensure or authorization to practice medicine by an out-of-
6729 state physician; (ii) reimbursement of telemedicine services performed by out-of-state
6730 physicians; (iii) patient cost sharing responsibilities of telemedicine services performed by out-

6731 of-state physicians; (iv) any liability concerns associated with an out-of-state physician
6732 practicing medicine in the commonwealth, and the ability of patients to pursue medical
6733 malpractice claims; (v) the ability for out-of-state physicians to maintain an interoperable
6734 electronic health record; and (vi) the ability of out-of-state physicians to meet meaningful use
6735 standards associated with the commonwealth's health information exchange. To the extent
6736 possible, the division shall review and report on any national or regional licensure standards that
6737 exist or are being considered, and their implications on licensure of out-of-state physicians in the
6738 commonwealth. The report shall include recommendations for legislation to permit the use of
6739 out-of-state physicians for telemedicine. The report shall be submitted to clerks of the house of
6740 representatives and the senate, and the joint committees on health care financing and financial
6741 services by July 1, 2013.

6742 SECTION 250. Notwithstanding any special or general law to the contrary, the executive
6743 office of health and human services, in collaboration with the department of veterans' services
6744 and the office of Medicaid shall study methods to improve access to Department of Veterans'
6745 Affairs benefits for qualified veterans, survivors and dependents currently enrolled in the
6746 MassHealth program. The study shall include, but not be limited to: (i) identifying barriers to
6747 assisting these individuals in obtaining federal veteran health care benefits; and (ii) an
6748 examination of the feasibility, costs and benefits of utilizing the federal public assistance
6749 reporting information system (PARIS) to identify veterans and their dependents or surviving
6750 spouses who are enrolled in the MassHealth program. The study shall also examine the process
6751 and any projected information technology costs of exchanging information with the federal
6752 public assistance reporting information system. If the executive office of health and human
6753 services determines that the financial benefits outweigh the costs of utilizing the federal public

6754 assistance reporting information system, the executive office of health and human services shall
6755 be authorized to enter into any agreements and undertake such other measures as necessary to
6756 utilize such system to identify eligible veterans, dependents and survivors. The executive office
6757 may also, if it determines that the benefits outweigh the costs, enter into an agreement with the
6758 department of veterans' services to perform veterans outreach services to assist qualified
6759 veterans, survivors and dependents in obtaining benefits. Any such agreement shall contain
6760 performance standards that will allow the secretary of health and human services to measure the
6761 effectiveness of the program established by this section. The secretary of health and human
6762 services shall report the findings of this study and any actions taken pursuant this section to the
6763 joint committee on veterans and federal affairs, the joint committee on health care financing, and
6764 the house and senate committees on ways and means not later than April 1, 2013.

6765 SECTION 251. Notwithstanding any general or special law to the contrary, the office of
6766 the state auditor shall conduct a comprehensive review of the impact of this act on the health care
6767 payment and delivery system in the commonwealth and on health care consumers, the health
6768 care workforce and general public.

6769 The review shall include, but not be limited to, an investigation of:

6770 (1) The impact on health care costs, including the extent to which savings have
6771 reduced out-of-pocket costs to individuals and families, health insurance premium costs and
6772 health care costs borne by the commonwealth;

6773 (2) The impact on access to health care services and quality of care in different
6774 regions of the state and for different populations, particularly for children, the elderly, low-
6775 income individuals, individuals with disabilities and other vulnerable populations;

6776 (3) The impact on access and quality of care for specific services, particularly
6777 primary care, behavioral, substance use disorder and mental health services;

6778 (4) The impact on the health care workforce, including, but not limited to, health
6779 care worker recruitment and retention, health care worker shortages, training and education
6780 requirements and job satisfaction; and

6781 (5) The impact on public health, including, but not limited to, reducing the
6782 prevalence of preventable health conditions, improving employee wellness and reducing racial
6783 and ethnic disparities in health outcomes.

6784 The office of the state auditor shall, to the extent possible, obtain and use data from the
6785 center for health information and analysis, the health policy commission, and the department of
6786 public health to conduct its analysis; provided, however, that such data shall be confidential and
6787 shall not be a public record under clause twenty-sixth of section 7 of chapter 4 of the General
6788 Laws. The office of the state auditor may contract with an outside organization to conduct this
6789 review.

6790 The office of the state auditor shall report the results of such review and its
6791 recommendations, if any, together with drafts of legislation necessary to carry out such
6792 recommendations to the house and senate committees on ways and means and the joint
6793 committee on public health and post the results on the state auditor's website not later than
6794 March 31, 2017.

6795 SECTION 252. Nothing in this act shall be construed to preclude an individual from
6796 obtaining additional insurance or paying out of pocket for any medical service not covered by the
6797 individual's health plan.

6798 SECTION 253. Notwithstanding any general or special law to the contrary, the executive
6799 office of health and human services shall require Medicaid, any carrier or other entity which
6800 contracts with the office of Medicaid to pay for or arrange for the purchase of health care
6801 services, the commonwealth care health insurance program established under chapter 118H of
6802 the General Laws, any carrier or other entity which contracts with the commonwealth care health
6803 insurance program to pay for or arrange for the purchase of health care services, and any other
6804 state sponsored or state managed plan providing health care benefits to reimburse any licensed
6805 hospital facility operating in the commonwealth that has been designated as a critical access
6806 hospital under U.S.C. 1395i-4, in an amount equal to at least 101 per cent of allowable costs
6807 under each such program, as determined by utilizing the Medicare cost-based reimbursement
6808 methodology, for both inpatient and outpatient services.

6809 SECTION 254. Notwithstanding any general or special law, or rule or regulation to the
6810 contrary, the commissioner of insurance shall promulgate regulations requiring any carrier, as
6811 defined in section 1 of chapter 176O of the General Laws, and their contractors to comply with
6812 and implement the federal Mental Health Parity and Addiction Equity Act, section 511 of Public
6813 Law 110-343, and applicable state mental health parity laws, including section 22 of chapter
6814 32A of the General Laws, section 47B of chapter 175 of the General Laws, section 8A of chapter
6815 176A of the General Laws, section 4A of chapter 176B of the General Laws and sections 4, 4B
6816 and 4M of chapter 176G of the General Laws. The commissioner of insurance shall promulgate
6817 said regulations not later than January 1, 2013. The regulations shall be implemented as part of
6818 any provider contract and any carrier's health benefit plans delivered, issued, entered into,
6819 renewed, or amended on or after July 31, 2013.

6820 Starting on July 1, 2014, the commissioner of insurance shall require all carriers and their
6821 contractors, to submit an annual report to the division of insurance and to the attorney general,
6822 which shall be a public record, certifying and outlining how their health benefit plans comply
6823 with the federal Mental Health Parity and Addiction Equity Act, applicable state mental health
6824 parity laws, including said section 22 of said chapter 32A, said section 47B of chapter 175, said
6825 section 8A of chapter 176A, said section 4A of chapter 176B and said sections 4, 4B and 4M of
6826 chapter 176G, and this section. The division of insurance may, at the request of the attorney
6827 general, or in its own discretion, hold a public hearing relative to a carrier's or contractor's
6828 annual report.

6829 SECTION 255. Notwithstanding the provisions of any general or special law or
6830 regulation to the contrary, the provisions of section 16T of chapter 6A of the General Laws shall
6831 not apply to the review of an application for a determination of need that is filed with the
6832 department of public health under any applicable provision of said chapter 6A on or before
6833 December 31, 2013.

6834 SECTION 256. Notwithstanding any general or special law to the contrary, the health
6835 planning council shall submit a state health plan to the governor and the general court, as
6836 required by section 16T of chapter 6A of the General Laws, on or before January 1, 2014.

6837 SECTION 257. Notwithstanding subsection (d) of section 25C of chapter 111, health care
6838 providers that receive written notice from the department of public health, prior to December 31,
6839 2013, that they do not need a determination of need review for a project shall be exempt from the
6840 requirement to file a determination of need under said subsection for such project.

6841 SECTION 258. Notwithstanding any general or special law to the contrary, the board of
6842 registration in medicine, established under section 10 of chapter 13 of the General Laws, may
6843 promulgate regulations relative to the education and training of physicians in the early disclosure
6844 of adverse events including, but not limited to, continuing education requirements. Nothing in
6845 this section shall affect the total hours of continuing education required by the board, including
6846 the number of hours required relative to risk management.

6847 SECTION 259. Notwithstanding any general or special law to the contrary, the
6848 department of public health, in consultation with the division of insurance, shall examine and
6849 study best practices and successful models of private sector wellness and health management
6850 programs in order to create a model wellness guide for payers, employers and consumers. The
6851 department shall also issue a report that identifies those elements of said programs that should be
6852 promoted in support of the state's efforts to meet the health care cost growth benchmark
6853 established under section 9 of chapter 6D of the General Laws.

6854 The model guide shall provide the following information: (i) the importance of healthy
6855 lifestyles, disease prevention, care management and health promotion programs; (ii) financial
6856 and other incentives for brokers, payers and consumers to encourage health and wellness
6857 program offerings for consumers and to expand options for individuals who do not have access
6858 to these programs through their workplace; (iii) benefit designs that tie financial consequences to
6859 health care choices; (iv) use of technology to provide wellness information and services; (v) the
6860 benefits of participating in tobacco cessation programs and weight loss programs; (vi) the
6861 importance of chronic disease management, and complying with prescribed drug and follow up
6862 treatment regimens to reduce hospitalization for high-risk populations; (vii) a description of the
6863 discounts available to employees under the Affordable Care Act; and (viii) identifying qualitative

6864 and quantitative program measures to place real value on program results and track program
6865 effectiveness.

6866 In developing the report and model guide, the commissioner shall consult with health
6867 care stakeholders, including but not limited to: employers, including representatives of
6868 employers with more than 50 employees and representatives of employers with less than 50
6869 employees; providers and provider organizations; health carriers; public payers; researchers;
6870 community organizations; consumers; and other governmental entities. The report, along with
6871 any recommendations, shall be submitted to the clerks of the house of representatives and the
6872 senate, the joint committee on health care financing, the house and senate committees on ways
6873 and means and the secretary of health and human services by January 1, 2013. The
6874 recommendations shall assist in the development of strategies and programs supported by the
6875 Prevention and Wellness Trust Fund established under section 2G of chapter 111 of the General
6876 Laws.

6877 SECTION 260. Notwithstanding any general or special law to the contrary, the board of
6878 registration in nursing, established under section 13 of chapter 13 of the General Laws, may
6879 promulgate regulations relative to the education and training of advanced practice nurses
6880 authorized to practice under section 80B of chapter 112 of the General Laws, in the early
6881 disclosure of adverse events including, but not limited to, continuing education requirements.
6882 Nothing in this section shall affect the total hours of continuing education required by the board.

6883 SECTION 261. Notwithstanding and special or general law to the contrary, the office of
6884 Medicaid shall develop alternative payment methodologies including, but not limited to,
6885 bundled payments, global payments, shared savings and other innovative methods of paying for

6886 health care services. The office of Medicaid shall take actions necessary to amend its managed
6887 care organization and primary care clinician contracts as necessary to include such contracts in
6888 the innovation project. In developing the innovation project that employs alternative payment
6889 methodologies, the office of Medicaid shall consider payment and quality metric alignment with
6890 existing accountable care demonstrations implemented by the Centers for Medicare and
6891 Medicaid Services. The office of Medicaid shall consult with stakeholders including, but not
6892 limited to, the health care quality and cost commission, hospitals or hospital associations, carriers
6893 or carrier associations, consumer groups, physician or physician associations, and other health
6894 care providers, including safety net providers and high Medicaid and low-income public payer
6895 hospitals on developing alternative payment methodologies under this section. The office of
6896 Medicaid shall ensure that alternative payment methodologies: (i) support the state's efforts to
6897 meet the health care cost growth benchmark and to improve health, care delivery and cost-
6898 effectiveness; (ii) include incentives for high quality, coordinated care, including wellness
6899 services, primary care services and behavioral health services; (iii) include a risk adjustment
6900 element based on health status; (iv) to the extent possible, include a risk adjustment element that
6901 takes into account functional status, socioeconomic status or cultural factors; (v) preserve the use
6902 of intergovernmental transfer financing mechanisms by governmental acute public hospitals
6903 consistent with the Medical Assistance Trust Fund provisions in effect as of fiscal year 2012; and
6904 (vi) recognize the unique circumstances and reimbursement requirements of high Medicaid
6905 disproportionate share hospitals and other safety net providers with concentrated care in
6906 government programs. The office of Medicaid may also consider methodologies to account for
6907 the following costs: (1) medical education; (2) stand-by services and emergency services,
6908 including, but not limited to, trauma units and burn units; ; (3) services provided by

6909 disproportionate share hospitals or other providers serving underserved populations, including
6910 but not limited to, groups which suffer adverse health outcomes based on race, sex, ethnicity,
6911 disability, housing type, income level, primary language or educational attainment; (4) services
6912 provided to children; (5) research; (6) care coordination and community based services provided
6913 by allied health professionals, including, but not limited to, community health workers, legal
6914 advocates, medical interpreters, clinical prevention specialists, human services workers, social
6915 workers and licensed alcohol and drug counselors; (7) the greater integration of behavioral,
6916 substance use disorder and mental health; (8) the use and the continued advancement of new
6917 medical technologies, treatments, diagnostics or pharmacology products that offer substantial
6918 clinical improvements and represent a higher cost than the use of current therapies; (9) culturally
6919 and linguistically appropriate services; (10) interpreter services; (11) dedicated care management
6920 responsibilities and administrative responsibilities in alternative payment methodologies; and
6921 (12) costs associated with the services of a comprehensive cancer center, as defined in section
6922 8A of chapter 118E of the General Laws.

6923 In making the transition to alternative payment methodologies, the office of Medicaid
6924 shall achieve the following benchmarks, to the maximum extent feasible:

6925 (i) Not later than July 1, 2013, the office of Medicaid shall pay for health care
6926 utilizing alternative payment methodologies for no fewer than 25 per cent of its enrollees that are
6927 not also covered by other health insurance coverage, including Medicare and employer-
6928 sponsored or privately purchased insurance.

6929 (ii) Not later than July 1, 2014, the office of Medicaid shall pay for health care
6930 utilizing alternative payment methodologies for no fewer than 50 per cent of its enrollees that are

6931 not also covered by other health insurance coverage, including Medicare and employer-
6932 sponsored or privately purchased insurance.

6933 (iii) Not later than July 1, 2015, the office of Medicaid shall pay for health care
6934 utilizing alternative payment methodologies for no fewer than 80 per cent or the maximum
6935 percentage feasible of its enrollees that are not also covered by other health insurance coverage,
6936 including Medicare and employer-sponsored or privately purchased insurance.

6937 SECTION 262. Notwithstanding any special or general law to the contrary, in fiscal year
6938 2014, the secretary of health and human services shall provide an increase of 2 per cent to rates
6939 paid by the office of medicaid to acute care hospitals, non-acute care hospitals and to providers
6940 of primary care services that accept alternative payment methodologies from the office of
6941 Medicaid or any Medicaid managed care organization. The amount of the rate increase shall not
6942 exceed \$20,000,000 in the aggregate, and shall be in addition to any annual rate calculations,
6943 including updates for inflation, case-mix adjustments, base year updates and any other
6944 improvements to the rate methodology. The office of Medicaid shall only apply this rate increase
6945 to those hospitals and providers that have demonstrated to the satisfaction of MassHealth a
6946 significant transition to the use of alternative payment methodologies. The rate increase to
6947 qualifying hospitals and providers shall apply to all health care services provided to medical
6948 assistance recipients including outpatient, inpatient and behavioral health services, including, but
6949 not limited to, those under primary care clinician and mental health and substance abuse plans or
6950 through a Medicaid managed care organization. The office of Medicaid may establish by
6951 regulation what constitutes a significant use of alternative payment methodologies by a provider.
6952 The office of Medicaid shall not offset the rate increase by reducing Medicaid base rates to acute

6953 hospitals or providers of primary care. The office of Medicaid shall, to the greatest extent
6954 possible, seek federal financial participation to offset the cost of implementing this section

6955 SECTION 263. Notwithstanding any general or special law to the contrary, the health
6956 policy commission shall investigate and review methods of, and make recommendations relative
6957 to, increasing the use and adoption of flexible spending accounts, health reimbursement
6958 arrangements, health savings accounts and similar tax-favored health plans and developing and
6959 implementing incentives to increase the utilization of these types of plans. The health policy
6960 commission shall examine the feasibility of such accounts and plans for public payers and
6961 commercial insurers and the feasibility of a pilot program. The health policy commission shall
6962 submit a report of its findings and recommendations to the clerks of the house of representatives
6963 and the senate, the house and senate committees on ways and means and the joint committee on
6964 health care financing not later than April 1, 2013.

6965 SECTION 264. Notwithstanding any general or special law to the contrary, the
6966 department of revenue shall conduct a study to investigate the implementation of a pilot program
6967 to increase the adoption of health reimbursement arrangements, health savings accounts, flexible
6968 spending accounts and similar plans in the marketplace, including state employees and persons
6969 receiving subsidized health care. The study commission shall be chaired by the commissioner of
6970 revenue and shall include: 1 member representing consumers appointed by the governor; 1
6971 member who shall be appointed by the president of the senate; 1 member who shall be appointed
6972 by the minority leader of the senate; 1 member who shall be appointed by the speaker of the
6973 house of representatives; 1 member who shall be appointed by the minority leader of the house
6974 of representatives; the executive director of the group insurance commission, or a designee; 1
6975 member who shall represent the Massachusetts Bankers Association; 1 member who shall

6976 represent the Massachusetts Association of Health Underwriters; 1 member who shall represent
6977 the Massachusetts Association of Health Plans; 1 member who shall represent Blue Cross and
6978 Blue Shield of Massachusetts; and 1 member who shall represent the Associated Industries of
6979 Massachusetts. The commission shall file a report with recommendations, and any legislation
6980 that may be necessary for implementation, with the clerks of the house of representatives and
6981 senate, the senate and house committees on ways and means and the joint committee on health
6982 care financing not later than April 1, 2013.

6983 The scope of the study shall include, but not be limited to, identifying: (i) the barriers to
6984 full implementation of flexible spending accounts, health reimbursement accounts, health
6985 savings accounts and other tax-favored health plans; (ii) providing greater consumer choice; and
6986 (iii) incentives to increase utilization of flexible spending accounts, health reimbursement
6987 accounts, health savings accounts and other tax-favored health plans.

6988 SECTION 265. Notwithstanding any general or special law or rule or regulation to the
6989 contrary, the office of Medicaid shall promulgate regulations requiring any Medicaid health plan
6990 and managed care organization and their health plans and any behavioral health management
6991 firm and third party administrator under contract with a Medicaid managed care organization to
6992 comply with and implement the federal Mental Health Parity and Addiction Equity Act, section
6993 511 of Public Law 110-343, and applicable state mental health parity laws, including section 22
6994 of chapter 32A, section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter
6995 176B and sections 4, 4B and 4M of chapter 176G of the General Laws. The office of Medicaid
6996 shall promulgate such regulations not later than January 1, 2013. The regulations shall be
6997 implemented as part of any provider contracts and any carrier's health benefit plans delivered,
6998 issued, entered into, renewed or amended on or after July 13, 2013.

6999 Starting on July 1, 2014, the office of Medicaid shall submit an annual report to the house
7000 and senate chairs of the joint committee on health care financing, the house and senate chairs of
7001 the joint committee on mental health and substance abuse, the clerk of the senate, the clerk of the
7002 house of representatives and the attorney general certifying and outlining how the health benefit
7003 plans under the office of Medicaid, and their contractors, comply with the federal Mental Health
7004 Parity and Addiction Equity Act, applicable state mental health parity laws, including said
7005 section 22 of said chapter 32A, said section 47B of said chapter 175, said section 8A of said
7006 chapter 176A, said section 4A of said chapter 176B, and said sections 4, 4B and 4M of said
7007 chapter 176G, and this section. The office of Medicaid may hold a hearing relative to a health
7008 benefit plan's or contractor's compliance with this section.

7009 SECTION 266. The office of Medicaid shall, within 6 months of the passage of this act,
7010 take any and all necessary actions to ensure that social security numbers are required on all
7011 medical benefits request forms to the extent permitted by federal law and that Social Security
7012 numbers are provided by all applicants who possess them. Further, the executive office of health
7013 and human services shall, within 6 months of the effective date of this act, ensure that the
7014 identity, age, residence and eligibility of all applicants are verified before payments, other than
7015 emergency bad debt payments, are made by the Health Safety Net Trust Fund;

7016 If for any reason the office of Medicaid or the executive office of health and human
7017 services determines that it is or will be unable to accomplish the foregoing within 6 months of
7018 the effective date of this act, said respective office shall submit a detailed report of the reasons
7019 for such inability to the clerks of the house of representatives and the senate within 6 months of
7020 the effective date of this act.

7021 SECTION 267. (a) Notwithstanding any general or special law to the contrary, the
7022 executive office of health and human services shall pursue all reasonable efforts to automatically
7023 renew eligible children and families into the MassHealth program, through the adoption of the
7024 express-lane eligibility option created under section 203 of the federal Children's Health
7025 Insurance Program Reauthorization Act of 2009, Public Law 111-3, as it pertains to renewals,
7026 and through the extension of that approach to all children and their eligible parents enrolled in
7027 medical assistance under chapter 118E of the General Laws. Specifically, the executive office
7028 shall seek federal authority under the section 1115 of the Social Security Act demonstration
7029 process or the state plan to automatically re-enroll all children and the eligible parents who are
7030 eligible for other state or federal assistance programs whose eligibility requirements are within
7031 the requirements for the applicable MassHealth program.

7032 (b) The executive office of health and human services shall provide families with renewal
7033 forms for all programs administered under said chapter 118E in which the fields have been pre-
7034 populated with the most current information known to the executive office. This subsection shall
7035 be effective not later than January 1, 2014.

7036 (c) There shall be a study committee to investigate the feasibility and cost of continuous
7037 MassHealth eligibility for children under the age of 19 to ensure that the same health care plans
7038 are offered through MassHealth and Commonwealth Care so that persons transitioning between
7039 different payers do not have to switch health plans. The committee shall consist of the following
7040 members: the director of the office of Medicaid, or a designee, who shall serve as chair; the
7041 secretary of health and human services, or a designee; the secretary of administration and
7042 finance, or a designee; the house chair of the joint committee on health care financing, or a
7043 designee; the senate chair of the joint committee on health care financing, or a designee; and a

7044 representative of health care consumers, to be appointed by the governor. The committee shall
7045 formulate relevant Medicaid state plan amendments, cost projections and information technology
7046 specifications necessary to implement continuous eligibility for children not later than June 30,
7047 2014.

7048 (d) Notwithstanding any general or special law to the contrary, the executive office of
7049 health and human services shall conduct an investigation of all federal and state assistance
7050 programs to determine which programs share eligibility requirements with MassHealth and
7051 which could feasibly share data with the MassHealth program for purposes of renewing eligible
7052 children and their eligible parents in MassHealth through the express-lane eligibility option
7053 created under said Children's Health Insurance Program Reauthorization Act of 2009, Public
7054 Law 111-3. The executive office shall submit a report on the results of such investigation by
7055 filing the same with the clerks of the house of representatives and the senate who shall forward
7056 the report to the house and senate committees on ways and means, the joint committee on health
7057 care financing and the joint committee on children and families and persons with disabilities not
7058 later than April 1, 2013."

7059 SECTION 268. Notwithstanding any general or special law to the contrary, to the extent
7060 that the office of Medicaid, the group insurance commission, the commonwealth health
7061 insurance connector authority and any other state funded insurance program determine that
7062 provider organizations organized as ACOs offer opportunities for cost-effective and high quality
7063 care, such state funded insurance programs shall prioritize provider organizations which have
7064 been certified by the board of the commission as ACOs, and designated as Model ACOs, for the
7065 delivery of publicly funded health services, provided that such ACOs, to the extent possible,
7066 assure the continuity of patient care.

7067 SECTION 269. Notwithstanding any special of general law to the contrary, for fiscal
7068 years 2013 through 2017 the center for health information and analysis and the health policy
7069 commission shall enter into an interagency agreement to transfer funds as necessary to support
7070 the transfer of functions from the center for health information and analysis to the health policy
7071 commission to supplement any funding needed in addition to those funds provided by the
7072 Healthcare Payment Reform Fund established in section 100 of chapter 194 of the acts of 2011.
7073 The executive director of the center for health information and analysis shall notify the
7074 comptroller of the amount to be transferred.

7075 SECTION 270. There shall be a special commission to review public payer
7076 reimbursement rates and payment systems for health care services and the impact of such rates
7077 and payment systems on health care providers and on health insurance premiums in the
7078 commonwealth. The commission shall consist of 13 members: 1 of whom shall be the secretary
7079 of health and human services or a designee, who shall serve as chair; 1 of whom shall be the
7080 director of the office of Medicaid; 1 of whom shall be the executive director of the center for
7081 health information and analysis; 1 of whom shall be appointed by the Massachusetts Hospital
7082 Association; 1 of whom shall be appointed by the Massachusetts Medical Society; 1 of whom
7083 shall be appointed by the Massachusetts Senior Care Association; 1 of whom shall be appointed
7084 by the Home Care Alliance of Massachusetts; 1 of whom shall be appointed by the
7085 Massachusetts League of Community Health Centers; 1 of whom shall be appointed by the
7086 Massachusetts Association for Behavioral Healthcare; 1 of whom shall represent a
7087 disproportionate share hospital; 1 of whom shall represent non-physician health care providers;
7088 and 2 of whom shall be appointed by the governor, 1 of whom shall be represent managed care

7089 organizations contracting with MassHealth and 1 of whom shall be an expert in medical payment
7090 methodologies from a foundation or academic institution.

7091 The commission shall examine whether public payer rates and rate methodologies
7092 provide fair compensation for health care services and promote high-quality, safe, effective,
7093 timely, efficient, culturally competent and patient-centered care. The commission's analysis shall
7094 include, but not be limited to, an examination of MassHealth rates and rate methodologies;
7095 current and projected federal financing, including Medicare rates; cost-shifting and the interplay
7096 between public payer reimbursement rates and health insurance premiums; possible funding
7097 sources for increased MassHealth rates including, but not limited to, utilizing increased federal
7098 Medicaid assistance percentage funds received under the Patient Protection and Affordable Care
7099 Act of 2010, Public Law 111-148, and section 1201 of the Health Care and Education
7100 Reconciliation Act of 2010, Public Law 111-152; and the degree to which public payer rates
7101 reflect the actual cost of care.

7102 To conduct its review and analysis, the commission may contract with an outside
7103 organization with expertise in the analysis of health care financing. The center for health
7104 information and analysis and the office of Medicaid shall provide the outside organization, to the
7105 extent possible, with any relevant data necessary for the evaluation; provided, however, that such
7106 data shall be confidential and shall not be a public record under clause Twenty-sixth of section 7
7107 of chapter 4 of the General Laws.

7108 The commission shall file the results of its study, together with drafts of legislation, if
7109 any, necessary to carry out its recommendations, by filing the same with the clerks of the house
7110 of representatives and the senate who shall forward a copy of the study to the house and senate

7111 committees on ways and means and the joint committee on health care financing not later than
7112 April 1, 2013.

7113 SECTION 271. Notwithstanding any law or rule the contrary, for fiscal year 2014, in
7114 establishing Medicaid reimbursement rates for inpatient services provided by chronic disease
7115 rehabilitation hospitals located in the commonwealth that serve solely children and adolescents,
7116 the department of health and human services shall apply a multiplier of 1.5 times the hospital's
7117 inpatient per diem rate in fiscal year 2012. For fiscal year 2015 and fiscal year 2016, such rates
7118 of reimbursement shall not be lower than the rates in effect for the prior fiscal year.

7119 SECTION 272. Notwithstanding any general or special law to the contrary, the
7120 department of public health, in consultation with the Betsy Lehman center for patient safety and
7121 medical error reduction, established under section 16E of chapter 6A of the General Laws, shall
7122 create an independent task force consisting of no more than 11 members from a broad
7123 distribution of diverse perspectives to study and reduce the practice of defensive medicine and
7124 medical overutilization in the commonwealth, including but not limited to the overuse of
7125 imaging and screening technologies. The task force shall issue a report on the financial and non-
7126 financial impacts of defensive medicine and the impact of overutilization on patient safety. The
7127 task force shall file a report of its study, including its recommendations and drafts of any
7128 legislation, if necessary, by filing the same with the clerks of the senate and house of
7129 representatives who shall forward a copy of the report to the joint committee on public health
7130 and the joint committee on health care financing within 1 year of the effective date of this act.

7131 SECTION 273. (a) There shall be a pharmaceutical cost containment commission
7132 established to study methods to reduce the cost of prescription drugs for both public and private

7133 payers. The commission shall consist of 16 members: 1 of whom shall be the senate chair of the
7134 joint committee on health care financing; 1 of whom shall be the house chair of the joint
7135 committee on health care financing; 1 of whom shall be the executive director of the group
7136 insurance commission or a designee; 1 of whom shall be the director of the division of insurance
7137 or a designee; 1 of whom shall be the director of the state office of pharmacy services or a
7138 designee; 1 of whom shall be the secretary of elder affairs or a designee; 1 of whom shall be the
7139 director of the Massachusetts Medicaid program or a designee; 3 of whom shall be appointed by
7140 the president of the senate, 1 of whom shall be appointed by the minority leader of the senate; 3
7141 of whom shall be appointed by the speaker of the house of representatives, 1 of whom shall be
7142 appointed by the minority leader of the house of representatives; 1 of whom shall be a
7143 representative of the Massachusetts Association of Health Plans; 1 of whom shall be a
7144 representative of the Massachusetts Hospital Association; and 1 of whom shall be a
7145 representative of Health Care For All.

7146 (b) The commission shall examine and report on the following: (i) the ability of the
7147 commonwealth to enter into bulk purchasing agreements, including agreements that would
7148 require the secretary of elder affairs, the executive director of the group insurance commission,
7149 the director of the state office of pharmacy services, the commissioners of the departments of
7150 public health, mental health and mental retardation, and any other state agencies involved in the
7151 purchase or distribution of prescription pharmaceuticals, to renegotiate current contracts; (ii)
7152 aggregate purchasing methodologies designed to lower prescription pharmaceutical costs for
7153 state and non-state providers; (iii) the ability of the commonwealth to operate as a single payer
7154 prescription pharmaceutical provider; and (iv) the feasibility of creating a program to provide all
7155 citizens access to prescription pharmaceuticals at prices negotiated by the commonwealth.

7156 (c) The commission shall report the results of its findings, together with any
7157 recommendations for legislation, programs and funding by filing the same with the clerks of the
7158 house of representatives and the senate who shall forward copies of the report to the house and
7159 senate committees on ways and means and the joint committee on health care financing not later
7160 than 12 months after the passage of this act.

7161 SECTION 274. There shall be a special task force to study and investigate issues related
7162 to the accuracy of medical diagnosis in the commonwealth. The task force shall investigate and
7163 report on: (i) the extent to which diagnoses in the commonwealth are accurate and reliable,
7164 including the extent to which different diagnoses and inaccurate diagnoses arise from the
7165 biological differences between the sexes; (ii) the underlying systematic causes of inaccurate
7166 diagnoses; (iii) an estimation of the financial cost to the state, insurers and employers of
7167 inaccurate diagnoses; (iv) the negative impact on patients caused by inaccurate diagnoses; and
7168 (v) recommendations to reduce or eliminate the impact of inaccurate diagnoses.

7169 The Massachusetts diagnostic accuracy task force shall be comprised of 9 members: 1 of
7170 whom shall be the secretary of health and human services, who shall chair the task force; 1 of
7171 whom shall be the commissioner of public health or a designee; 1 of whom shall be the chair of
7172 the board of registration in medicine or a designee; 1 of whom shall be the chair of the board of
7173 registration in nursing or a designee; and 5 members chosen by the governor, 1 of whom shall be
7174 a provider with experience in the area of diagnostic accuracy, 1 of whom shall be a representative
7175 of a Massachusetts health plan, 1 of whom shall be an employer with experience in
7176 implementing programs to address diagnostic inaccuracy, 1 whom shall represent an
7177 organization based in the commonwealth with experience creating and supporting the

7178 implementation of programs on diagnostic accuracy and value-based benefit design, and 1 of
7179 whom shall be a non-physician health care provider.

7180 SECTION 275. There shall be a special task force to examine behavioral, substance use
7181 disorder, and mental health treatment, service delivery, integration of behavioral health with
7182 primary care, and behavioral, substance use disorder and mental health reimbursement systems.
7183 The task force shall consist of 19 members: 1 whom shall be the commissioner of mental health,
7184 who shall serve as the chair; 1 of whom shall be a representative of the Massachusetts
7185 Psychiatric Society; 1 of whom shall be a representative of the Massachusetts Psychological
7186 Association; 1 of whom shall be a representative of the National Association of Social Workers-
7187 Massachusetts Chapter; 1 of whom shall be a representative of the Massachusetts Mental Health
7188 Counselors Association; 1 of whom shall be a representative of the Nurses United for
7189 Responsible Services; 1 of whom shall be a representative of the Massachusetts Association for
7190 Registered Nurses; 1 of whom shall be a representative of the Massachusetts Association of
7191 Behavioral Health Systems; 1 of whom shall be a representative of the Association for
7192 Behavioral Healthcare ; 1 of whom shall be a representative of the Mental Health Legal Advisors
7193 Committee; 1 of whom shall be a representative of the National Alliance for the Mentally Ill; 1
7194 of whom shall be a representative of the Children's Mental Health Campaign; 1 of whom shall
7195 be a representative of the Home Care Alliance of Massachusetts; 1 of whom shall be a
7196 representative of the National Empowerment Center; 1 of whom shall be a representative of the
7197 Massachusetts Organization for Addiction Recovery; 1 of whom shall be a representative of the
7198 Recovery Homes Collaborative; 1 of whom shall be a representative of the Massachusetts
7199 Hospital Association; and 3 members chosen by the Governor: 1 of whom shall be a provider
7200 with experience serving difficult to reach populations; 1 of whom shall be a provider with

7201 experience in severing dually diagnosed patients; and 1 of whom shall be a school nurse. In its
7202 examination, the task force shall review: (i) the most effective and appropriate approach to
7203 including behavioral, substance use and mental health disorder services in the array of services
7204 provided by provider organizations, including risk-bearing providers and patient-centered
7205 medical homes, including transition planning and maintaining continuity of care; (ii) how current
7206 prevailing reimbursement methods and covered behavioral, substance use and mental health
7207 benefits may need to be modified to achieve more cost effective, integrated and high quality
7208 behavioral, substance use and mental health outcomes; (iii) the extent to which and how payment
7209 for behavioral health services should be included under alternative payment methodologies,
7210 including how mental health parity and patient choice of providers and services could be
7211 achieved and the design and use of medical necessity criteria and protocols; (iv) how best to
7212 educate all providers to recognize behavioral, substance use and mental health conditions and
7213 make appropriate decisions regarding referral to behavioral health services; (v) how best to
7214 educate all providers about the effects of cardiovascular disease, diabetes, and obesity on patients
7215 with serious mental illness; and (vi) the unique privacy factors required for the integration of
7216 behavioral, substance use and mental health information into interoperable electronic health
7217 records. The task force shall submit its report, findings, and recommendations, along with any
7218 proposed legislation and regulatory changes, to the health policy commission, the clerks of the
7219 senate and house of representatives, and the house and senate chairs of the joint committee on
7220 mental health and substance abuse, and the house and senate chairs of the joint committee on
7221 health care financing not later than July 1, 2013.

7222 SECTION 276. (a) There shall be a commission on prevention and wellness which shall
7223 evaluate the effectiveness of the program authorized under section 2G of chapter 111 of the

7224 General Laws. The commission shall consist of 20 members: 1 of whom shall be the
7225 commissioner of public health or a designee, who shall serve as the chair; 1 of whom shall be the
7226 executive director of the center for health information and analysis established in chapter 12C or
7227 a designee; 1 of whom shall be the secretary of health and human services or a designee; 2 of
7228 whom shall be the house and senate chairs of the joint committee on public health; 2 of whom
7229 shall be the house and senate chairs of the joint committee on health care financing; and 13 of
7230 whom shall be appointed by the governor, 1 of whom shall be a person with expertise in the field
7231 of public health economics, 1 of whom shall be a person with expertise in public health research,
7232 1 of whom shall be a person with expertise in the field of health equity, 1 of whom shall be a
7233 person from a local board of health for a city or town with a population greater than 50,000, 1 of
7234 whom shall be a person of a board of health for a city or town with a population less than 50,000,
7235 2 of whom shall be representatives of health insurance carriers, 1 of whom shall be a person from
7236 a consumer health organization, 1 of whom shall be a person from a hospital association, 1 of
7237 whom shall be a person from a statewide public health organization, 1 of whom shall be a
7238 representative of the interest of businesses, 1 of whom shall be a person representing frontline
7239 registered nurses and 1 of whom shall be a person from an association representing community
7240 health workers.

7241 (b) The commission shall review the program authorized under said section 2G of said
7242 chapter 111 and shall issue a report. The report shall include an analysis of all relevant data to
7243 determine the effectiveness and return on investment of the program including, but not limited
7244 to, an analysis of: (i) the extent to which the program impacted the prevalence of preventable
7245 health conditions; (ii) the extent to which the program reduced health care costs or the growth in
7246 health care cost trends; (iii) whether health care costs were reduced, and who benefitted from the

7247 reduction; (iv) the extent to which workplace-based wellness or health management programs
7248 were expanded, and whether those programs improved employee health, productivity and
7249 recidivism; (v) if employee health and productivity was improved or employee recidivism was
7250 reduced, the estimated statewide financial benefit to employers; (vi) recommendations for
7251 whether the program should be discontinued, amended or expanded, as well as a timetable for
7252 implementation of the recommendations; and (vii) recommendations for whether the funding
7253 mechanism for the Prevention and Wellness Trust Fund should be extended beyond 2016, or
7254 whether an alternative funding mechanism should be established

7255 (c) To conduct its evaluation, the commission shall contract with an outside organization
7256 with expertise in the analysis of health care financing. In conducting its evaluation, the outside
7257 organization shall, to the extent possible, obtain and use actual health plan data from the all-
7258 payer claims database as administered by the center for health information and analysis;
7259 provided, however, that such data shall be confidential and shall not be a public record under
7260 clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

7261 (d) The commission shall report the results of its investigation and study and its
7262 recommendation, if any, together with drafts of legislation necessary to carry out such
7263 recommendation to the house and senate committees on ways and means, the joint committee on
7264 public health and shall be posted on the department's website not later than June 30, 2015.

7265 SECTION 277. There shall be a special commission to examine the economic, social and
7266 educational value of graduate medical education in the commonwealth and to recommend a fair
7267 and sustainable model for the future funding of graduate medical education in the
7268 commonwealth.

7269 The commission shall consist of 13 members: 1 of whom shall be the secretary of health
7270 and human services or a designee, who shall serve as chair; 1 of whom shall be the secretary of
7271 administration and finance or a designee; 1 of whom shall be the secretary of labor and
7272 workforce development or a designee; 1 of whom shall be the commissioner of public health or a
7273 designee; and 9 whom shall be appointed by the secretary of health and human services, 1 of
7274 whom shall be a representative of the Massachusetts Hospital Association; 1 of whom shall be a
7275 representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the
7276 Massachusetts League of Community Health Centers; 4 of whom shall represent the
7277 commonwealth's medical schools; 1 of whom shall be a representative of the Conference of
7278 Boston Teaching Hospitals; and 1 of whom shall be a resident in training at a Massachusetts
7279 hospital.

7280 The commission shall investigate and report on the following issues:

7281 (1) the role of residents and medical faculty in the provision of health care in the
7282 commonwealth and throughout the United States;

7283 (2) the relationship of graduate medical education to the state's physician workforce and
7284 emerging models of delivery of care;

7285 (3) the current availability and adequacy of all sources of revenue to support graduate
7286 medical education and potential additional or alternate sources of funding for graduate medical
7287 education. Such review shall include the availability of federal graduate medical education
7288 funding to different types of sites where training takes place; and

7289 (4) approaches taken by other states to fund graduate medical education through,
7290 including, but not limited to: (a) Medicaid programs, (b) the establishment of medical education
7291 trust funds and (c) efforts to link payments to state policy goals, including:

7292 (i) increasing the number of high demand specialties or fellowships;

7293 (ii) enhancing retention of physicians practicing in the commonwealth;

7294 (iii) promoting practice in medically underserved areas of the state and reducing
7295 disparities in health care;

7296 (iv) increasing the primary care workforce;

7297 (v) increasing the behavioral health care workforce; and

7298 (vi) increasing racial and ethnic diversity within the physician workforce.

7299 The commission shall file a report of its findings and recommendations, together with
7300 drafts of legislation, if any, necessary to carry out its recommendations by filing the report with
7301 the clerks of the house of representatives and the senate who shall forward a copy of the report to
7302 the house and senate committees on ways and means and the joint committee on health care
7303 financing not later than April 1, 2013.

7304 SECTION 278. Notwithstanding any general or special law to the contrary, beginning on
7305 or before July 1, 2014, the group insurance commission, MassHealth and any other state funded
7306 insurance program shall, to the maximum extent feasible, implement alternative payment
7307 methodologies, as defined in section 1 of chapter 12C of the General Laws.

7308 SECTION 279. There shall be a special commission to review variation in prices among
7309 providers. The commission shall consist of 18 members: 1 of whom shall be the executive
7310 director of the center of health information and analysis or a designee, who shall serve as co-
7311 chair; 1 of whom shall be the executive director of the health policy commission, who shall serve
7312 as co-chair; 1 of whom shall be the secretary of administration and finance or a designee; 1 of
7313 whom shall be the executive director of the group insurance commission or a designee; 1 of
7314 whom shall be the secretary of health and human services or a designee; 1 of whom shall be the
7315 attorney general or a designee; 6 of whom shall be appointed by the governor, 1 of whom shall
7316 be a health economist, 1 of whom shall represent a high Medicaid and low-income public payer
7317 disproportionate share hospital, 1 of whom shall represent a hospital with 200 beds or less, 1 of
7318 whom shall represent a pharmaceutical manufacturer who shall be headquartered in the
7319 commonwealth, 1 of whom shall be a representative of an employer with less than 50 employees,
7320 and 1 of whom shall be a representative of an employer with more than 50 employees; 1 of
7321 whom shall be a representative of the Massachusetts Council of Community Hospitals; 1 of
7322 whom shall be a representative of the Massachusetts Association of Health Plans, Inc.; 1 of
7323 whom shall be a representative of Blue Cross and Blue Shield of Massachusetts, Inc.; 1 of whom
7324 shall be a representative of the Massachusetts Hospital Association, Inc.; 1 of whom shall be a
7325 representative of the Massachusetts Medical Society; 1 of whom shall be a representative of a
7326 medical device manufacturer who shall be headquartered in the commonwealth; and 1 of whom
7327 shall be a representative of the Conference of Boston Teaching Hospitals. In making
7328 appointments, the governor shall, to the maximum extent feasible, ensure that the commission
7329 represents a broad distribution of diverse perspectives.

7330 The commission shall conduct a rigorous, evidence based analysis to identify the
7331 acceptable and unacceptable factors contributing to price variation in physician, hospitals,
7332 diagnostic testing and ancillary services. The analysis shall include, but not be limited to, an
7333 examination of the following factors: quality, medical education, stand-by service capacity,
7334 emergency service capacity, special services provided by disproportionate share hospitals and
7335 other providers serving underserved or unique populations, market share of individual providers
7336 and affiliated providers, provider size, advertising, location, research, costs, care coordination,
7337 community-based services provided by allied health professionals and use of and continued
7338 advancement of medical technology and pharmacology. The analysis shall also include a
7339 comparison of price variation between providers in the commonwealth and providers in other
7340 states and a review of the feasibility of requiring insurers to separately contract with all provider
7341 locations for a multi-location provider, rather than contracting only with the individual provider
7342 locations and a review of contracting practices that require payers to pay the same or similar
7343 prices to all provider locations for a multi-location health care provider where geographic
7344 differences in the provider's site do not support charging the same or similar prices.

7345 After identifying the factors contributing to price variation, the commission shall
7346 recommend steps to reduce provider price variation and shall recommend the maximum
7347 reasonable adjustment to a commercial insurer's median rate for individual or groupings of
7348 services for each acceptable factor. To conduct its review and analysis, the commission may
7349 contract with an outside organization with expertise in the analysis of health care financing and
7350 provider payment methodologies. The center for health information and analysis shall provide
7351 the commission and any contracted outside organization, to the extent possible, relevant data

7352 necessary for the evaluation; provided, however, that such data shall be confidential and shall not
7353 be a public record under clause Twenty-sixth of section 7 of chapter 4 of the General Laws.

7354 The commission shall file the results of its study, together with drafts of legislation, if
7355 any, necessary to carry out its recommendations, by filing the study with the health policy
7356 commission and the clerks of the house of representatives and the senate who shall forward a
7357 copy of the study to the house and senate committees on ways and means and the joint
7358 committee on health care financing not later than January 1, 2014.

7359 SECTION 280. (a) Notwithstanding any general or special law to the contrary, the group
7360 insurance commission, the commonwealth health insurance connector authority, the office of
7361 Medicaid and any other state funded insurance program shall implement, to the maximum extent
7362 possible, alternative payment methodologies. The alternative payment methodologies shall be
7363 developed in consultation with all affected publically funded health plans, including, but not
7364 limited to, the Medicaid managed care organizations; provided, however, that any such agency or
7365 program shall be subject to any other implementation requirements provided for by law.

7366 (b) The executive office of health and human services shall seek a federal waiver of
7367 statutory provisions necessary to permit Medicare to participate in such alternative payment
7368 methodologies. Upon obtaining federal approval for Medicare participation, such participation
7369 shall be commenced and continued and the executive office shall seek extensions or additional
7370 approvals, as necessary. If federal approval cannot be obtained, or is revoked, then the
7371 requirements of this chapter, shall be conformed to federal standards for accountable care, shared
7372 savings, bundled payments, or alternative payment arrangements, to the greatest extent
7373 practicable.

7374 (c) Private health plans shall to the maximum extent feasible reduce the use of fee-for-
7375 service payment mechanisms in order to promote high quality, efficient care delivery.

7376 SECTION 281. (a) Notwithstanding any general or special law to the contrary, this
7377 section shall facilitate the orderly transfer of employees, proceedings, rules and regulations,
7378 property and legal obligations of the following functions of state government from the transferor
7379 agency to the transferee agency, defined as follows:

7380 (1) the functions of the division of health care finance and policy, as the transferor
7381 agency, to the center for health information analysis and the health policy commission, as the
7382 transferee agencies; provided however, that this section shall not apply to the functions of the
7383 division of health care finance and policy that relate to the administration of the health safety net
7384 fund and that relate to the administration of the fair share assessment;

7385 (2) the functions of the division of health care finance and policy related to the
7386 administration of the health safety net fund, as the transferor agency, to the office of Medicaid,
7387 as the transferee agency;

7388 (3) the functions of the division of health care finance and policy related to the
7389 administration of the fair share assessment, as the transferor agency, to the commonwealth health
7390 insurance connector authority, as the transferee agency;

7391 (3) the functions of the health care quality and cost council, as the transferor agency, to
7392 the health policy commission, as the transferee agency; provided, however, that this section shall
7393 not apply to the functions of the health care quality and cost council that relate to the
7394 administration of the consumer health information website;

7395 (4) the functions of the health care quality and cost council related to the
7396 consumer health information website, as the transferor agency, to the center for health
7397 information analysis, as the transferee agency;

7398 (4) the functions of the department of public health related to the statewide advisory
7399 committee on the standard quality measure set, as the transferor agency, to the center for health
7400 information analysis, as the transferee agency;

7401 (5) the functions of the department of public health related to the office of patient
7402 protection, as the transferor agency, to the health policy commission, as the transferee agency;

7403 (6) the functions of the Betsy Lehman center for patient safety and medical error
7404 reduction, as the transferor agency, to the center for health information analysis, as the transferee
7405 agency;

7406 (b) To the extent that employees of the transferor agency, including those who were
7407 appointed immediately before the effective date of this act and who hold permanent appointment
7408 in positions classified under chapter 31 of the General Laws or have tenure in their positions as
7409 provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold
7410 confidential positions, are transferred to the respective transferee agency, such transfers shall be
7411 effected without interruption of service within the meaning of said section 9A of said chapter 30,
7412 without impairment of seniority, retirement or other rights of the employee, and without
7413 reduction in compensation or salary grade, notwithstanding any change in title or duties resulting
7414 from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and
7415 benefits, and without change in union representation or certified collective bargaining unit as
7416 certified by the state division of labor relations or in local union representation or affiliation. Any

7417 collective bargaining agreement in effect immediately before the transfer date shall continue in
7418 effect and the terms and conditions of employment therein shall continue as if the employees had
7419 not been so transferred. The reorganization shall not impair the civil service status of any such
7420 reassigned employee who immediately before the effective date of this act either holds a
7421 permanent appointment in a position classified under said chapter 31 or has tenure in a position
7422 by reason of said section 9A of said chapter 30. Notwithstanding any other general or special law
7423 to the contrary, all such employees shall continue to retain their right to collectively bargain
7424 under chapter 150E of the General Laws and shall be considered employees for the purposes of
7425 said chapter 150E. Nothing in this section shall be construed to confer upon any employee any
7426 right not held immediately before the date of said transfer, or to prohibit any reduction of salary
7427 grade, transfer, reassignment, suspension, discharge, layoff or abolition of position not prohibited
7428 before such date.

7429 (c) All petitions, requests, investigations and other proceedings appropriately and duly
7430 brought before the transferor agency or duly begun by the transferor agency and pending before
7431 it before the effective date of this act, shall continue unabated and remain in force, but shall be
7432 assumed and completed by the transferee agency.

7433 (d) All orders, rules and regulations duly made and all approvals duly granted by the
7434 transferor agency, which are in force immediately before the effective date of this act, shall
7435 continue in force and shall thereafter be enforced, until superseded, revised, rescinded or
7436 canceled, in accordance with law, by the transferee agency.

7437 (e) All books, papers, records, documents, equipment, buildings, facilities, cash and other
7438 property, both personal and real, including all such property held in trust, which immediately

7439 before the effective date of this act are in the custody of the transferor agency shall be transferred
7440 to the transferee agency.

7441 (f) All duly existing contracts, leases and obligations of the transferor agency shall
7442 continue in effect but shall be assumed by the transferee agency. No existing right or remedy of
7443 any character shall be lost, impaired or affected by this act.

7444 (g) The comptroller shall be authorized to take any actions necessary to support the
7445 transfers outlined in this section. No existing right or remedy of any character shall be lost,
7446 impaired or affected by this act.

7447 SECTION 281A. The division of insurance shall develop uniform prior authorization
7448 forms for different health care services and benefits under subsections (c) and (d) of section 24 of
7449 chapter 176O of the General Laws not later than October 1, 2013.

7450 SECTION 281B. The division of insurance shall promulgate regulations to implement
7451 section 26 of chapter 176O of the General Laws not later than July 1, 2014.

7452 SECTION 283. Section 13 of chapter 6D of the General Laws shall take effect on
7453 January 1, 2013.

7454 SECTION 284. Section 6 of said chapter 6D shall take effect on July 1, 2016.

7455 SECTION 285. Section 228 of chapter 111 of the General Laws shall take effect on
7456 January 1, 2014.

7457 SECTION 286. Section 7 of chapter 118I of the General Laws shall take effect on
7458 January 1, 2017.

7459 SECTION 287. Section 6 of said chapter 118I shall take effect on January 1, 2017.

7460 SECTION 288. Section 108M of chapter 175 of the General Laws shall take effect on
7461 October 1, 2013.

7462 SECTION 289. Section 37 of chapter 176A of the General Laws shall take effect on
7463 October 1, 2013.

7464 SECTION 290. Section 24 of chapter 176B of the General Laws shall take effect on
7465 October 1, 2013.

7466 SECTION 291. Section 32 of chapter 176G of the General Laws shall take effect on
7467 October 1, 2013.

7468 SECTION 292. Section 17 of chapter 176J of the General Laws shall take effect on
7469 October 1, 2013.

7470 SECTION 293. Section 24 of chapter 176O of the General Laws shall take effect on
7471 October 1, 2013.

7472 SECTION 294. Section 25 of said chapter 176O shall take effect on January 1, 2014.

7473 SECTION 295. Section 36 shall take effect on October 1, 2013.

7474 SECTION 296. Section 37 shall take effect on October 1, 2014.

7475 SECTION 297. Section 41 and section 56 shall take effect on January 1, 2013.

7476 SECTION 298. Section 41A and 56A shall take effect on December 31, 2017.

7477 SECTION 299. Section 108 shall take effect as of January 1, 2015.

7478 SECTION 301. Sections 141 and 142 shall take effect on July 1, 2013.

7479 SECTION 302. Section 175 shall take effect on April 1, 2014.

7480 SECTION 303. Section 176 shall take effect on April 1, 2015.

7481 SECTION 304. Section 199 shall take effect on October 1, 2015.

7482 SECTION 305. Section 200 shall take effect on October 1, 2013.

7483 SECTION 306. Section 271 is hereby repealed.

7484 SECTION 307. Section 306 shall take effect on June 30, 2016.

7485 SECTION 308. Section 177 shall take effect on April 1, 2013.