HOUSE DOCKET, NO. 682 FILED ON: 1/18/2011

HOUSE . . . . . No. 339

The Commonwealth of Massachusetts

PRESENTED BY:

Ronald Mariano

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to strengthening the determination of need process.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Ronald Mariano	*3rd Norfolk*

HOUSE . . . . . No. 339

By Mr. Mariano of Quincy, a petition (accompanied by bill, House, No. 339) of Ronald Mariano relative to strengthening the determination of need process. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 HOUSE
 , NO. *1089* OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to strengthening the determination of need process.

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

SECTION 1. Chapter 305 of the Acts of 2008 is hereby amended by deleting section 7 and replacing it with the following new language:

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

for, or the acquisition of, any replacement of medical, diagnostic or therapeutic equipment defined as new technology or innovative services for which a determination of need has issued or which was exempt from determination of need, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; provided further, that expenditures and acquisitions concerned solely with outpatient services other than ambulatory surgery, not otherwise defined as new technology or innovative services by the department, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum, unless the expenditures and acquisitions are at least $7,500,000, in which case a determination of need shall be required. Notwithstanding the above limitations, acute care hospitals only may elect at their option to apply for determination of need for expenditures and acquisitions less than the expenditure minimum.

Chapter 305 of the Acts of 2008 is hereby further amended in section 11 by deleting the last paragraph and replacing it with the following new language:

Section 53G. Any entity that is certified or seeking certification as an ambulatory surgical center by the Centers for Medicare and Medicaid Services for participation in the Medicare program shall be a clinic for the purpose of licensure under section 51, and shall be deemed to be in compliance with the conditions for licensure as a clinic under said section 51 if it is accredited to provide ambulatory surgery services by the Accreditation Association for Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities or any other national accrediting body that the department determines provides reasonable assurances that such conditions are met. No original license shall be issued pursuant to said section 51 to establish any such ambulatory surgical clinic unless there is a determination by the department that there is a need

for such a facility. For purposes of this section, "clinic" shall include a clinic conducted by a hospital licensed under said section 51 or by the federal government or the commonwealth. The department shall promulgate regulations to implement this section.

SECTION 2. Section 25C of chapter 111 of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting after the first paragraph the following new paragraph:

"The Department shall conduct a statewide planning initiative for the purposes of studying and coordinating the availability and delivery of health care services within the commonwealth. The initiative shall examine the current supply of inpatient and outpatient services, and technologies and develop a plan for the provision of new services, beds, technologies, and structural expansions throughout the commonwealth, and develop a plan for the continued role of community hospitals and health centers within the commonwealth. The Department shall utilize this plan in its evaluation of all applications for a determination of need, as required by this section, in order to determine whether the proposed expansion construction, or acquisition of health care facilities or services is needed in the Commonwealth, or whether the proposed expansion construction, or acquisition of health care facilities or services will unnecessary duplicate ongoing services and increase health care costs in the Commonwealth."

Section 25C of chapter 111 of the General Laws is further amended by inserting at the end of the section the following new paragraph:

"Any hospital seeking to expand its emergency department shall file a determination of need with the department. In addition to the information required pursuant to this section, the department shall require hospitals seeking emergency department expansions to demonstrate that prior to filing a determination of need application; the hospital has implemented measures to

reduce emergency room overcrowding. The department shall promulgate regulations defining the measures hospitals may take to reduce emergency room overcrowding."

Section 25C of chapter 111 of the General Laws is further amended by inserting at the end of the 2nd paragraph the following language:

"Each person or agency of the commonwealth or any political subdivision thereof filing a determination of need to acquire new technology shall, in addition to the information required by this section, file with the department documentation of programs implemented by the health care facility designed to ensure utilization of all new technology in a manner that is consistent with state and national guidelines. The department shall annually publish a list of state and national guidelines governing the utilization of new technology. The department shall promulgate regulations necessary to enforce this section."

Section 25C of chapter 111 of the General Laws is further amended by deleting the last sentence of the 7th paragraph and replacing it with the following new language:

"A reasonable fee, established by the department, shall be paid upon the filing of such application. The fee shall be adjusted annually as necessary to accommodate the volume of new applications."

SECTION 3. Section 3 of chapter 17 of the General Laws is hereby amended by deleting section 3 in its entirety and replacing it with the following new language:

Section 3. (a) There shall be a public health council to advise the commissioner of public health and to perform other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 17 members appointed for terms of 6 years under this section.

The commissioner may designate 1 of the members as vice-chairperson and may appoint sub-committees or special committees as needed.

(b) Four of the members shall be appointed by the governor: 1 shall be appointed from among the chancellor of the University of Massachusetts Medical School and a list of 3 nominated by said chancellor; 1 shall be appointed from among the dean of the University of Massachusetts Amherst School of Public Health or Health Sciences and a list of 3 nominated by said dean; 1 shall be appointed from among the heads of the non-public schools of medicine in the commonwealth or their nominees; and 1 shall be appointed from among the heads of the non-public schools or programs in public health in the commonwealth or their nominees.

(c) Four of the appointed members shall be providers of health services, appointed by the governor: 1 of whom shall have expertise in acute care hospital management; 1 of whom shall have expertise in long term care management; 1 of whom shall have expertise in home or community-based care management, and 1 of whom shall have expertise in the practice of primary care medicine or public health nursing.

(d) Six of the appointed members shall be non-providers: 1 shall be appointed by the secretary of elder affairs; 1 shall be appointed by the secretary of veterans' services; 1 shall be appointed by the governor from a list of 3 nominated by Health Care For All, Inc.; 1 shall be appointed by the governor from a list of 3 nominated by the Coalition for the Prevention of Medical Errors, Inc.; 1 shall be appointed by the governor from a list of 3 nominated by the Massachusetts Public Health Association; and 1 shall be appointed by the governor from a list of 3 nominated by the Massachusetts Community Health Worker Network. Whenever an organization nominates a list of candidates for appointment by the governor under this subsection, the organization may

nominate additional candidates if the governor declines to appoint any of those originally nominated.

(e) Three of the appointed members shall be payers of health care, appointed by the governor: 1 shall represent a health plan licensed in the Commonwealth; 1 shall represent small businesses; and one shall represent large businesses.

(f) For purposes of this section, "non-provider" shall mean a person whose background and experience indicate that he is qualified to act on the council in the public interest; who, and whose spouse, parents, siblings or children, have no financial interest in a health care facility; who, and whose spouse has no employment relationship to a health care facility, to a nonprofit service corporation established under chapters 176A to 176E, inclusive, or to a corporation authorized to insure the health of individuals; and who, and whose spouse, is not licensed to practice medicine.

(g) Upon the expiration of the term of office of an appointive member, his successor shall be appointed in the same manner as the original appointment, for a term of 6 years and until the qualification of his successor. The members shall be appointed not later than 60 days after a vacancy. The council shall meet at least once a month, and at such other times as it shall determine by its rules, or when requested by the commissioner or any 4 members. The appointive members shall receive $100 per day that the council meets, and their reasonably necessary traveling expenses while in the performance of their official duties.

HOUSE DOCKET, NO. 966 FILED ON: 1/19/2011

HOUSE . . . . . No. 341

The Commonwealth of Massachusetts

PRESENTED BY:

William Smitty Pignatelli

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act creating a rate methodology for critical access hospitals.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
William Smitty Pignatelli	*4th Berkshire*
Benjamin B. Downing	*Berkshire, Hampshire, and Franklin*
Anne M. Gobi	*5th Worcester*
Timothy R. Madden	*Barnstable, Dukes and Nantucket*
Stephen Kulik	*1st Franklin*
Daniel A. Wolf	*Cape and Islands*

HOUSE . . . . . No. 341

By Mr. Pignatelli of Lenox, a petition (accompanied by bill, House, No. 341) of William Smitty Pignatelli and others relative to Medicaid payments to critical access hospitals. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 HOUSE
 , NO. *4513* OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act creating a rate methodology for critical access hospitals.

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

SECTION 1. Section 111 of chapter 118G of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by adding the following subsection:

(d) Notwithstanding any general or special law to the contrary, the executive office of health and human services shall reimburse, and shall require all Medicaid managed care organizations to reimburse, any licensed hospital facility operating in the commonwealth that has been designated a critical access hospital pursuant to 42 U.S.C. §1395i-4 in an amount equal to at least one hundred and one percent (101%) of the allowable Medicare costs for both inpatient and outpatient services provided to patients of such facility enrolled in the Masshealth program.

SECTION 2. Section 5 of chapter 176Q of the General Laws, as so appearing, is hereby amended by adding the following subsection:

(e)The commonwealth health insurance connector authority shall require all carriers with which it contracts to provide the commonwealth care health insurance program to reimburse any licensed hospital facility operating in the commonwealth that has been designated a critical access hospital pursuant to 42 U.S.C. §1395i-4 in an amount equal to at least one hundred and one percent (101%) of the allowable Medicare costs for both inpatient and outpatient services provided to patients of such facility enrolled in the commonwealth care program.

HOUSE DOCKET, NO. 196 FILED ON: 1/11/2011

HOUSE . . . . . No. 345

The Commonwealth of Massachusetts

PRESENTED BY:

John W. Scibak

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to health care affordability.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
John W. Scibak	*2nd Hampshire*
Stephen Kulik	*1st Franklin*
Ruth B. Balser	*12th Middlesex*
Kay Khan	*11th Middlesex*
Patricia D. Jehlen	*Second Middlesex*
Timothy J. Toomey, Jr.	*26th Middlesex*
James B. Eldridge	*Middlesex and Worcester*
David Paul Linsky	*5th Middlesex*
Jonathan Hecht	*29th Middlesex*
Michael R. Knapik	*Second Hampden and Hampshire*
Christine E. Canavan	*10th Plymouth*
Brian M. Ashe	*2nd Hampden*
John P. Fresolo	*16th Worcester*
Frank I. Smizik	*15th Norfolk*
William Smitty Pignatelli	*4th Berkshire*
Carl M. Sciortino, Jr.	*34th Middlesex*
Michael D. Brady	*9th Plymouth*
Cheryl A. Coakley-Rivera	*10th Hampden*

Elizabeth A. Malia	*11th Suffolk*

HOUSE . . . . . No. 345

By Mr. Scibak of South Hadley, a petition (accompanied by bill, House, No. 345) of John W. Scibak and others for legislation to establish a division of health insurance under the supervision and control of the commissioner of health insurance. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 HOUSE
 , NO. *1102* OF 2009-2010.]

The Commonwealth of Massachusetts

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In the Year Two Thousand Eleven

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An Act relative to health care affordability.

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

SECTION 1. The third sentence of the first paragraph of subsection (d) of section 38C of chapter 3 of the General Laws is hereby amended by striking out the words "the division of insurance" and inserting in place thereof the following words:– the division of health insurance.

SECTION 2. The second paragraph of section 16 of chapter 6A of the General Laws is hereby amended by striking out the words "and (7) the health facilities appeals board" and inserting in place thereof the following words:– (7) the health facilities appeals board; and (8) the division of health insurance under the direction of the commissioner of health insurance.

SECTION 3. The second sentence of subsection (a) of section 16D of chapter 6A of the General Laws is hereby amended by striking out the words "the commissioner of insurance" and inserting in place thereof the following words:– the commissioner of health insurance.

SECTION 4. The first sentence of subsection (b) of section 16K of chapter 6A of the General Laws is hereby amended by striking out the words “the commissioner of insurance” and inserting in place thereof the following words:– the commissioner of health insurance.

SECTION 5. Sections 7A and 7B of chapter 26 of the General Laws are hereby repealed.

SECTION 6. The first paragraph of section 8H of chapter 26 of the General Laws is hereby amended by adding the following sentence:– Assessments received under this paragraph from domestic health insurance companies, including nonprofit hospital, medical and dental service corporations as defined in section 1 of chapter 176A, section 1 of chapter 176B, and section 1 of chapter 176E shall be paid to the division of health insurance.

SECTION 7. Section 8H of chapter 26 of the General Laws is hereby amended by striking out the third and forth paragraphs.

SECTION 8. The first sentence of section 3 of chapter 32A of the of the General Laws is hereby amended by striking out the words “the commissioner of insurance” and inserting in place thereof the following words:– the commissioner of health insurance.

SECTION 9. Subsection (a) of section 2 of chapter 111M of the General Laws is hereby amended by inserting after the words “established by chapter 176Q” the following:- by regulation, in accordance with the requirements of subsection (d).

SECTION 10. The first sentence of subsection (b) of said section 2 of said chapter 111M of the General Laws is hereby amended by striking out clauses (ii) and (iii) and inserting in place thereof the following clauses:- (ii) claims an exemption under section 3, (iii) had a certificate issued under section 3 of chapter 176Q, or (iv) had adjusted gross income as shown on the

individual's state tax return such that the amount required to purchase the lowest cost insurance on the market for which an individual would be eligible for creditable coverage, taking into consideration the out of pocket costs, as shown in the schedule created pursuant to subsection (p) of section 3 of chapter 176Q, exceeds the amount which an individual could be expected to contribute towards the purchase of insurance in the report published pursuant to subsection (q) of section 3 of chapter 176Q.

SECTION 11. Said section 2 of chapter 111M of the General Laws, as so appearing, is hereby further amended by inserting after subsection (c) the following subsections:-

(d) The affordability schedule set by the board of the connector pursuant to subsection (a) shall be subject to the following requirements:

(1) in determining whether creditable coverage is affordable, the board of the connector shall consider expected enrollee expenditures as the 90th percentile of out of pocket costs plus premiums for those enrolled in creditable coverage;

(2) For the purposes of this section, "out-of-pocket costs" shall mean the amount paid by an enrollee to satisfy the applicable annual deductible, co–payments and co-insurance, not including monthly premiums.

SECTION 12. The General Laws are hereby amended by inserting after chapter 111M the following chapter:¬–

Chapter 111N.

Division of Health Insurance.

Section 1. There is hereby established a division of health insurance under the supervision and control of the commissioner of health insurance. The secretary of health and human services shall appoint the commissioner, with the approval of the governor, who shall serve at the pleasure of the secretary and may be removed by the secretary at any time, subject to the approval of the governor. The commissioner shall have such educational qualifications and administrative and other experience as the secretary of health and human services determines to be necessary for the performance of the duties of commissioner. The position of commissioner shall be classified in accordance with section 45 of chapter 30 and the salary shall be determined in accordance with section 46C of said chapter 30.

The commissioner shall appoint and may remove such agents and subordinate officers as the commissioner may deem necessary and may establish bureaus and subdivisions within the division. The division shall adopt and amend rules and regulations, in accordance with chapter 30A, for the administration of its duties and powers and to effectuate the provisions and purposes of this chapter and other duties of the division.

Section 2. There shall be in the division a health care access bureau overseen by a deputy commissioner for health care access, whose duties shall include, subject to the direction of the commissioner of health insurance, administration of the division's statutory and regulatory authority for oversight of the small group and individual health insurance market, oversight of affordable health plans, including coverage for young adults, as well as the dissemination of appropriate information to consumers about health insurance coverage and access to affordable products. The commissioner shall appoint at least the following employees of the health care access bureau: a deputy commissioner for health access, a health care finance expert, an actuary, and a research analyst. They shall devote their full time to the duties of their office, shall be

exempt from chapters 30 and 31, and shall serve at the pleasure of the commissioner. The commissioner may appoint such other employees as the bureau may require.

The commissioner may make and collect an assessment against the carriers licensed under chapters 175, 176A, 176B and 176G to pay for the expenses of the bureau. The assessment shall be at a rate sufficient to produce $600,000 annually. In addition to that amount, the assessment shall include an amount to be credited to the General Fund which shall be equal to the total amount of funds estimated by the secretary for administration and finance to be expended from the General Fund for indirect and fringe benefit costs attributable to the personnel costs of the bureau. If the commissioner fails to expend for the costs and expenses of the bureau in a fiscal year the total amount of $600,000 for the purposes set forth in this section, any amount unexpended in that fiscal year shall be credited against the assessment to be made in the following fiscal year, and the assessment in the following fiscal year shall be reduced by that unexpended amount. The assessment shall be allocated on a fair and reasonable basis among all carriers licensed under said chapters 175, 176A, 176B and 176G. The funds produced by the assessments shall be expended by the division, in addition to any other funds which may be appropriated, to assist in defraying the general operating expenses of the bureau, and may be used to compensate consultants retained by the bureau. A carrier licensed under said chapters 175, 176A, 176B and 176G shall pay the amount assessed against it within 30 days after the date of the notice of assessment from the commissioner.

Section 3. (a) For the purposes of implementing chapter 111M and section 8B of chapter 62C, the commissioner may consult with the department of revenue and may enter into an interdepartmental service agreement with the department that may include the transfer of information from statements and reports provided under said section 8B.

(b) Upon request, carriers licensed under chapters 175, 176A, 176B and 176G and the office of Medicaid shall make information available to the bureau for the purposes of chapter 111M. Such information shall be limited to the minimum amount of personal information necessary, shall not include information about diagnoses or treatments and, except for the office of Medicaid, shall not include social security numbers. The information acquired under this section shall be confidential and shall not constitute a public record.

(c) The division may consider violations of this section and said section 8B when licensing or authorizing entities to provide health coverage.

Section 4. The division, in consultation with the commonwealth health insurance connector established by chapter 176Q, shall establish and publish minimum standards and guidelines at least annually for each type of health benefit plans, except qualified student health insurance plans as set forth in section 18 of chapter 15A, provided by insurers and health maintenance organizations doing business in the commonwealth.

Section 5. The division shall require all health insurers and health maintenance organizations doing business in the commonwealth to identify persons who are recipients of medical assistance under chapter one hundred and eighteen E or recipients of health care services, including hospital and other services funded through the uncompensated care pool under section 18 of chapter 118G, or who are responsible for supporting such recipients, and who are also beneficiaries under any policy for health insurance or parties to any health maintenance contract in force and effect in the commonwealth. The department of public welfare and the division of health care finance and policy shall provide information to the extent sufficient to allow all insurers to identify such persons. Such information shall be made available by such insurers and health

maintenance organizations and by the department and the division of health care finance and policy only for the purposes of and to the extent necessary for identifying such persons. No health insurer or health maintenance organization which complies with this section shall be liable in any civil or criminal action or proceedings brought by such beneficiaries or members on account of such compliance. The division of health insurance shall further direct all health insurers and health maintenance organizations doing business in the commonwealth to participate with the department and the division of health care finance and policy in any procedures, including but not limited to automated file matches, conducted under the direction of the department and the division of health care finance and policy for the purpose of identifying those persons who are recipients of medical assistance under chapter 118E or recipients of health care services, including hospital and other services funded through the uncompensated care pool, under section 18 of chapter 118G, or who are responsible for supporting such recipients, and who are also beneficiaries under any policy for health insurance or parties to any health maintenance contract in force in the commonwealth. Participation in such a procedure by a health insurer or health maintenance organization doing business in the commonwealth shall include but not be limited to reasonable financial participation in the cost of any such procedure. The commissioner of health insurance is authorized to promulgate regulations necessary to ensure the effectiveness of this section

Section 6. (a)As used in this section the following words shall have the following meanings, unless the context clearly requires otherwise:-

"Adjusted weighted average market premium price", the arithmetic mean of all premium rates for a given prototype plan sold to eligible insureds with similar rate basis type by all carriers selling

prototype plans or alternative prototype plans in the commonwealth, weighted pursuant to regulations promulgated by the commissioner.

“Alternative prototype plan”, a health plan which meets the criteria established by the commissioner and which is intended for sale under section 4 of chapter 176Q, to eligible individuals and to eligible small groups, as defined in section 1 of chapter 176Q.

"Carrier", an insurer licensed or otherwise authorized to transact accident and health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a non-profit medical service corporation organized under chapter 176B; or a health maintenance organization organized under chapter 176G.

“Health plan”, any individual, general, blanket or group policy of health, accident or sickness insurance issued by an insurer licensed under chapter 175 or the laws of any other jurisdiction; a hospital service plan issued by a nonprofit hospital service corporation under chapter 176A or the laws of any other jurisdiction; a medical service plan issued by a nonprofit hospital service corporation under chapter 176B or the laws of any other jurisdiction; a health maintenance contract issued by a health maintenance organization under chapter 176G or the laws of any other jurisdiction; and an insured health benefit plan that includes a preferred provider arrangement issued under chapter 176I or the laws of any other jurisdiction. “Health plan” shall not include accident only, credit-only, limited scope dental or vision benefits if offered separately, hospital indemnity insurance policies if offered as independent, noncoordinated benefits which for the purposes of this chapter shall mean policies issued pursuant to chapter 175 which provide a benefit not to exceed $500 per day, as adjusted on an annual basis by the amount of increase in the average weekly wages in the commonwealth as defined in section 1 of

chapter 152, to be paid to an insured or a dependent, including the spouse of an insured, on the basis of a hospitalization of the insured or a dependent, disability income insurance, coverage issued as a supplement to liability insurance, specified disease insurance that is purchased as a supplement and not as a substitute for a health plan and meets any requirements the commissioner by regulation may set, insurance arising out of a workers' compensation law or similar law, automobile medical payment insurance, insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in a liability insurance policy or equivalent self insurance, long-term care if offered separately, coverage supplemental to the coverage provided under 10 U.S.C. chapter 55 if offered as a separate insurance policy, or any policy subject to the provisions of chapter 176K. The commissioner may by regulation define other health coverage as a health plan for the purposes of this chapter.

"Prototype plan", a health plan which meets the criteria established by the commissioner.

"Rate basis type", each category of individual or family composition for which separate rates are charged for a health benefit plan as determined by the carrier subject to restrictions set forth in regulations promulgated by the commissioner.

(b) After a date established annually by the commissioner pursuant to regulation, every carrier desiring to increase or decrease premiums for any health insurance policy or desiring to set the initial premium for a new health insurance policy under any health plan shall file its rates with the commissioner at least 90 days before the proposed effective date of such new health insurance rates.

(c) Any increase in premium rates shall continue in effect for not less than 12 months, except that an increase in benefits or decrease in rates may be permitted at any time.

(d) A carrier shall annually report to the commissioner and to the health care quality and cost council, established under section 16K of chapter 6A, no later than May 1, the actual loss ratio calculated for each health plan for the previous calendar year.

(e) If a carrier files for an increase in premium of 7 per cent or more than the premium previously charged for any rate classification or coverage, or if a carrier files an initial premium request that is 7 per cent or more than the adjusted weighted average market premium price, or if the attorney general files with the commissioner, within 30 days of the carrier's filing, a preliminary determination that the benefits provided in any health insurance policy are unreasonable in relation to the premium charged, the commissioner shall initiate a hearing conducted pursuant to chapter 30A on any such filing prior to its effective date on at least 10 days notice. The commissioner may consolidate hearings for more than 1 carrier, and may consolidate hearings for multiple health plans filed by one carrier. The carrier shall provide information on the reasons for the proposed premium increase, and members of the public may testify. All testimony and evidence received shall be public records. The commissioner may promulgate guidelines to safeguard the confidentiality of contracts that establish rates between insurers and institutional providers licensed under section 51 of chapter 111 which shall apply when the commissioner obtains such contracts under his authority in section 8A of chapter 175 for purposes of a hearing under this section.

The attorney general shall have the authority to intervene in any hearing called for under this section.

Such requested premium increase or initial premium request shall be filed at least 90 days before the proposed effective date of such increase, and shall be communicated to the insureds at least

90 days before the proposed effective date of such increase, in the manner directed by the commissioner.

The rate filer shall advertise any public hearing conducted under this section in newspapers in Boston, Brockton, Fall River, Pittsfield, Springfield, Worcester, New Bedford and Lowell.

Within 30 days of the conclusion of any hearing initiated under this section, the commissioner shall issue a report containing findings of fact from the evidence presented in the carrier's filing and in the hearing. The findings of fact shall include, but shall not be limited to:

the carrier's administrative expenses, including but not limited to the carrier's salary structure, advertising and other marketing expenses, and commissions, brokerage fees and other distribution expenses, as compared to other carriers within and without the commonwealth;

the carrier's expenses related to health care contract, including but not limited to the costs of services rendered by health care providers, the rates at which it pays for such services and the volume of services provided;

the carrier's loss experience under the health plan, including evaluations of the carrier's loss ratio and of utilization by the carrier's insureds, and of identifiable cost drivers for that health plan, as compared to other carriers within and without the commonwealth;

cost-sharing assumptions made in the health plan, including, but not limited to, the use of deductibles, co-payments and coinsurance;

the carrier's provisions in the rates for reserves and surplus; and

the carrier's programs of cost containment, as compared to other carriers within and without the commonwealth.

Nothing in this paragraph shall be construed to prohibit the attorney general from publishing any report concerning a hearing under this section.

This section is not intended to alter any procedures for the approval or disapproval of health plan rates provided elsewhere in the General Laws, except as specifically provided herein.

The commissioner shall promulgate regulations to specify the conduct and scheduling of the hearings required pursuant to this section, provided that any such regulation shall facilitate adequate discovery of information related to the filed rates.

(f) The supreme judicial court shall have jurisdiction in equity upon the petition of the attorney general, on behalf of the commissioner and upon a summary hearing, to enforce all lawful orders of the commissioner.

Any person aggrieved by any final action, order, finding or decision of the commissioner under this section may, within 20 days from the filing of such final action, order, finding or decision in his office, file a petition in the supreme judicial court for the county of Suffolk for a review of such action, order, finding or decision. The final action, order, finding, or decision of the commissioner shall remain in full force and effect, pending the final decision of the court, unless the court or a justice thereof after notice to the commissioner shall by a special order otherwise direct. Review by the court on the merits shall be limited to the record of proceedings before the commissioner. The court shall have jurisdiction to modify, amend, annul, reverse or affirm such action, order, finding or decision and shall uphold the commissioner's action, order, finding, or decision if it is consistent with the standards set forth in paragraph 7 of section 14 of chapter 30A. The court may make any appropriate order or decree and may make such order as to costs as it deems equitable. The court may make such rules or orders as it deems proper governing

proceedings under this section to secure prompt and speedy hearings and to expedite final decisions thereon.

(g) The commissioner may promulgate regulations to facilitate the administration and enforcement of this section and to govern hearings and investigations thereunder, and may issue such orders as he finds proper, expedient or necessary to enforce and administer this chapter and to secure compliance with any rules and regulations made thereunder.

SECTION 13. Clause (ii) of the second paragraph of subsection (d) of section 2 of chapter 118G of the General Laws is hereby amended by striking out the words "the division of insurance" and inserting in place thereof the following words:– the division of health insurance.

SECTION 14. Clause (i) of the second sentence of the third paragraph of section 6 of chapter 118G of the General Laws is hereby amended by striking out the words "the division of insurance under section 8H of chapter 26" and inserting in place thereof the following words:– the division of health insurance.

SECTION 15. The second sentence of subsection (b) of section 6½ of chapter 118G of the General Laws is hereby amended by striking out the words "the division of insurance" and inserting in place thereof the following words:– the division of health insurance.

SECTION 16. Section 1 of chapter 175 of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of insurance; provided, that the term "Commissioner" shall mean the commissioner of health insurance established by chapter 111N with respect to all

health insurance, including accident and sickness insurance under sections 108 and 110 and any other insurance that provides medical, surgical, dental, or hospital expense benefits.

SECTION 17. Section 2 of chapter 175I of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of insurance or his designee; provided, that the term "Commissioner" shall mean the commissioner of health insurance established by chapter 111N with respect to all health insurance.

SECTION 18. Section 1 of chapter 176A of the General Laws is hereby amended by inserting before the first paragraph the following paragraph:–

Notwithstanding any general or special law to the contrary, the words "commissioner" and "commissioner of insurance" as used in this chapter shall mean the commissioner of health insurance.

SECTION 19. Section 1 of chapter 176B of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 20. Section 1 of chapter 176D of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of insurance; provided, that the terms "Commissioner" and "commissioner of the division of insurance" shall mean the commissioner of health insurance established by chapter 111N with respect to all health insurance, including accident and sickness

insurance under sections 108 and 110 and any other insurance that provides medical, surgical, dental, or hospital expense benefits.

SECTION 21. Section 1 of chapter 176E of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 22. Section 1 of chapter 176G of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 23. Section 1 of chapter 176I of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 24. Section 1 of chapter 176J of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 25. Section 1 of chapter 176K of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 26. Section 1 of chapter 176M of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 27. Section 1 of chapter 176N of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 28. Section 1 of chapter 176O of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 29. Section 1 of chapter 176O of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 30. Said section 1 of said chapter 176O of the General Laws is hereby amended by striking out the definition of "Division" and inserting in place thereof the following definition:–

"Division", the division of health insurance.

SECTION 31. Section 1 of chapter 176Q of the General Laws is hereby amended by striking out the definition of "Commissioner" and inserting in place thereof the following definition:–

"Commissioner", the commissioner of health insurance.

SECTION 32. The second sentence of subsection (b) of section 2 of chapter 176Q of the General Laws is hereby amended by striking out the words "the commissioner of insurance" and inserting in place thereof the following words:– the commissioner of health insurance.

SECTION 33. Subsection (m) of section 3 of chapter 176Q of the General Laws is hereby amended by striking out the words “the division of insurance” and inserting in place thereof the following words:– the division of health insurance.

SECTION 34. Section 1 of chapter 176R of the General Laws is hereby amended by striking out the definition of “Commissioner” and inserting in place thereof the following definition:–

“Commissioner”, the commissioner of health insurance.

SECTION 35. (a) Notwithstanding any general or special law to the contrary, this section shall facilitate the orderly transfer of the employees, proceedings, rules and regulations, property and legal obligations and functions of state government from the division of insurance, solely to the extent that they relate to health insurance, as transferor agency, to the division of health insurance, as transferee agency.

(b) Subject to appropriation, the employees of the transferor agency, including those who immediately before the effective date of this act held permanent appointment in positions classified under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A of chapter 30 of the General Laws or did not hold such tenure, or held confidential positions, are hereby transferred to the transferee agency, without interruption of service within the meaning of section 9A of chapter 30, without impairment of seniority, retirement or other rights of the employee, and without reduction in compensation or salary grade, notwithstanding any change in title or duties resulting from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and benefits, and without change in union representation or certified collective bargaining unit as certified by the state labor relations commission or in local union representation or affiliation. Any collective bargaining agreement in effect

immediately before the transfer date shall continue in effect and the terms and conditions of employment therein shall continue as if the employees had not been so transferred. The reorganization shall not impair the civil service status of any such reassigned employee who immediately before the effective date of this act either held a permanent appointment in a position classified under chapter 31 of the General Laws or had tenure in a position by reason of section 9A of chapter 30 of the General Laws.

(c) Notwithstanding any general or special law to the contrary, all such employees shall continue to retain their right to bargain collectively pursuant to chapter 150E of the General Laws and shall be considered employees for the purposes of chapter 150E.

Nothing in this section shall confer upon any employee any right not held immediately before the date of the transfer, or to prohibit any reduction of salary grade, transfer, reassignment, suspension, discharge or layoff not prohibited before such date; nor shall anything in this section prohibit the abolition of any management position within the divisions of telecommunications or community antenna television after transfer to the department.

(d) All petitions, requests, investigations, filings and other proceedings appropriately and duly brought before the transferor agency, or pending before it before the effective date of this act, shall continue unabated and remain in force, but shall be assumed and completed by the transferee agency.

(e) All orders, advisories, findings, rules and regulations duly made and all approvals duly granted by the transferor agency, which are in force immediately before the effective date of this act, shall continue in force and shall thereafter be enforced, until superseded, revised, rescinded or canceled, in accordance with law, by the transferee agency.

(f) All books, papers, records, documents, equipment, buildings, facilities, cash and other property, both personal and real, including all such property held in trust, which immediately before the effective date of this act are in the custody of the transferor agency, shall be transferred to the transferee agency.

(g) All duly existing contracts, leases and obligations of the transferor agency, shall continue in effect but shall be assumed by the transferee agency. No such existing right or remedy of any character shall be lost, impaired or affected by this act.

(h) Whenever the term “division of insurance” appears in any statute, regulation, contract or other document, it shall be taken to mean the division of health insurance to the extent that it relates to health insurance. Otherwise, it shall be continue to be taken to mean the division of insurance.

HOUSE DOCKET, NO. 772 FILED ON: 1/19/2011

HOUSE . . . . . No. 628

The Commonwealth of Massachusetts

PRESENTED BY:

Christopher N. Speranzo

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to developing an HIT revolving loan program .

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Christopher N. Speranzo	*3rd Berkshire*

HOUSE . . . . . No. 628

By Mr. Speranzo of Pittsfield, a petition (accompanied by bill, House, No. 628) of Christopher N. Speranzo for legislation to establish a health innovation revolving loan fund to assist providers in obtaining health information technology. Public Health.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to developing an HIT revolving loan program .

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

SECTION 1: Chapter 40J of the General Laws, as so appearing, is hereby amended by inserting after section 6G the following two sections:

(6H) There shall be established and set up on the books of the corporation the Massachusetts E-Health Innovation Revolving Loan Fund, hereinafter referred to as the fund, for the sole purpose of supporting a healthcare provider, as defined in section 1 of chapter 111, to comply with state and federal requirements for the adoption of health information technology in the commonwealth, including, but not limited to, the full deployment of electronic health records. There shall be credited to the fund any appropriations, proceeds of any bonds or notes of the commonwealth issued for the purpose, or other monies authorized by the general court and designated thereto; any federal grants or loans; any private gifts, grants or donations made available; and any income derived from the investment of amounts credited to the fund. The director of the institute shall seek, to the greatest extent possible, private gifts, grants and donations to the fund. The corporation shall hold the fund in an account or accounts separate

from other funds. The fund shall be administered by the executive director without further appropriation; provided, however, that any disbursement or expenditure from the fund for loans to healthcare providers, as provided in section 6I, shall be approved by the health information technology council established under said section 6D. Amounts credited to the fund shall be available for reasonable expenditure by the corporation, subject to the approval of the health information technology council where such approval is required under this chapter, for such purposes as the corporation determines are necessary to support the dissemination and development of health information technology in the commonwealth, including, but not limited to, the loan program established in said section 6I.

(6I) The Massachusetts e-Health Institute shall make no-interest loans from the E-Health Innovation Revolving Loan Fund to healthcare providers, as defined in section 1 of chapter 111, to assist with, but not limited to, the development and implementation of an interoperable health information technology system that meets federal and/or state requirements. The director of the institute shall determine the size and number of loans made, and may prescribe forms or establish an application process and may impose a reasonable nonrefundable application fee to cover the cost of administering the loan program. Any application fees imposed and collected under this clause are to be reinvested in the E-Health Innovation Revolving Loan Fund for the duration of the loan program. To be eligible for a loan under this section, a healthcare provider, at a minimum, must provide the institute with the following information: (1) the amount of the loan requested and a description of the purpose or project for which the loan proceeds will be used; (2) a quote from a vendor; (3) a description of the health care provider/entities and other groups participating in the project; (4) evidence of financial stability and a demonstrated ability to repay

the loan; and (5) a description of how the system to be financed shall bring the healthcare provider into compliance with federal and/or state requirements.

HOUSE DOCKET, NO. 1463 FILED ON: 1/20/2011

HOUSE . . . . . No. 1220

The Commonwealth of Massachusetts

PRESENTED BY:

Michael A. Costello

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act strengthening the DON program.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Michael A. Costello	*1st Essex*

HOUSE . . . . . No. 1220

By Mr. Costello of Newburyport, a petition (accompanied by bill, House, No. 1220) of Michael A. Costello relative to the medical facility determination of need program. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act strengthening the DON program.

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

SECTION 1

Chapter 305 of the Acts of 2008 is hereby amended by deleting Section 7 and replacing it with the following new language:

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

for, or the acquisition of, any replacement of medical, diagnostic or therapeutic equipment defined as new technology or innovative services for which a determination of need has issued or which was exempt from determination of need, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; provided further, that expenditures and acquisitions concerned solely with outpatient services other than ambulatory surgery, not otherwise defined as new technology or innovative services by the department, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum, unless the expenditures and acquisitions are at least $7,500,000, in which case a determination of need shall be required. Notwithstanding the above limitations, acute care hospitals only may elect at their option to apply for determination of need for expenditures and acquisitions less than the expenditure minimum.

Chapter 305 of the Acts of 2008 is hereby further amended by in Section 11 deleting the last paragraph and replacing it with the following new language:

Section 53G. Any entity that is certified or seeking certification as an ambulatory surgical center by the Centers for Medicare and Medicaid Services for participation in the Medicare program shall be a clinic for the purpose of licensure under section 51, and shall be deemed to be in compliance with the conditions for licensure as a clinic under said section 51 if it is accredited to provide ambulatory surgery services by the Accreditation Association for Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities or any other national accrediting body that the department determines provides reasonable assurances that such conditions are met. No original license shall be issued pursuant to said section 51 to establish any such ambulatory surgical clinic unless there is a determination by the department that there is a need

for such a facility. For purposes of this section, “clinic” shall include a clinic conducted by a hospital licensed under said section 51 or by the federal government or the commonwealth. The department shall promulgate regulations to implement this section.

SECTION 2

Section 25C of Chapter 111 of the General Laws is amended by inserting after the first paragraph the following new paragraph:

“The Department shall conduct a statewide planning initiative for the purposes of studying and coordinating the availability and delivery of health care services within the commonwealth. The initiative shall examine the current supply of inpatient and outpatient services, and technologies and develop a plan for the provision of new services, beds, technologies, and structural expansions throughout the commonwealth, and develop a plan for the continued role of community hospitals and health centers within the commonwealth. The Department shall utilize this plan in its evaluation of all applications for a determination of need, as required by this section, in order to determine whether the proposed expansion construction, or acquisition of health care facilities or services is needed in the Commonwealth, or whether the proposed expansion construction, or acquisition of health care facilities or services will unnecessary duplicate ongoing services and increase health care costs in the Commonwealth.”

SECTION 3

Section 25C of Chapter 111 of the General Laws is amended by inserting at the end of the section the following new paragraph:

"Any hospital seeking to expand its emergency department shall file a determination of need with the department. In addition to the information required pursuant to this section, the department shall require hospitals seeking emergency department expansions to demonstrate that prior to filing a determination of need application, the hospital has implemented measures to reduce emergency room overcrowding. The department shall promulgate regulations defining the measures hospitals may take to reduce emergency room overcrowding."

Section 25C of Chapter 111 of the General Laws is further amended by inserting at the end of the 2nd paragraph the following language:

"Each person or agency of the commonwealth or any political subdivision thereof filing a determination of need to acquire new technology shall, in addition to the information required by this section, file with the department documentation of programs implemented by the health care facility designed to ensure utilization of all new technology in a manner that is consistent with state and national guidelines. The department shall annually publish a list of state and national guidelines governing the utilization of new technology. The department shall promulgate regulations necessary to enforce this section."

Section 25C of Chapter 111 of the General Laws is further amended by deleting the last sentence of the 7th paragraph and replacing it with the following new language:

"A reasonable fee, established by the department, shall be paid upon the filing of such application. The department shall be adjusted annually as necessary to accommodate the volume of new applications."

Section 3 of Chapter 17 of the General Laws is hereby amended by deleting Section 3 in its entirety and replacing it with the following new language:

Section 3. (a) There shall be a public health council to advise the commissioner of public health and to perform other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 17 members appointed for terms of 6 years under this section. The commissioner may designate 1 of the members as vice chairperson and may appoint subcommittees or special committees as needed.

(b) Four of the members shall be appointed by the governor: 1 shall be appointed from among the chancellor of the University of Massachusetts Medical School and a list of 3 nominated by said chancellor; 1 shall be appointed from among the dean of the University of Massachusetts Amherst School of Public Health or Health Sciences and a list of 3 nominated by said dean; 1 shall be appointed from among the heads of the non-public schools of medicine in the commonwealth or their nominees; and 1 shall be appointed from among the heads of the non-public schools or programs in public health in the commonwealth or their nominees.

(c) Four of the appointed members shall be providers of health services, appointed by the governor: 1 of whom shall have expertise in acute care hospital management; 1 of whom shall have expertise in long term care management; 1 of whom shall have expertise in home or community-based care management, and 1 of whom shall have expertise in the practice of primary care medicine or public health nursing.

(d) Six of the appointed members shall be non-providers: 1 shall be appointed by the secretary of elder affairs; 1 shall be appointed by the secretary of veterans' services; 1 shall be appointed by the governor from a list of 3 nominated by Health Care For All, Inc.; 1 shall be appointed by the governor from a list of 3 nominated by the Coalition for the Prevention of Medical Errors, Inc.; 1 shall be appointed by the governor from a list of 3 nominated by the Massachusetts Public Health Association; and 1 shall be appointed by the governor from a list of 3 nominated by the Massachusetts Community Health Worker Network. Whenever an organization nominates a list of candidates for appointment by the governor under this subsection, the organization may nominate additional candidates if the governor declines to appoint any of those originally nominated.

(e) Three of the appointed members shall be payers of health care, appointed by the governor: 1 shall represent a health plan licensed in the Commonwealth; 1 shall represent small businesses; and one shall represent large businesses.

(f) For purposes of this section, "non-provider" shall mean a person whose background and experience indicate that he is qualified to act on the council in the public interest; who, and whose spouse, parents, siblings or children, have no financial interest in a health care facility; who, and whose spouse has no employment relationship to a health care facility, to a nonprofit service corporation established under chapters 176A to 176E, inclusive, or to a corporation authorized to insure the health of individuals; and who, and whose spouse, is not licensed to practice medicine.

(g) Upon the expiration of the term of office of an appointive member, his successor shall be appointed in the same manner as the original appointment, for a term of 6 years and until the qualification of his successor. The members shall be appointed not later than 60 days after a vacancy. The council shall meet at least once a month, and at such other times as it shall determine by its rules, or when requested by the commissioner or any 4 members. The appointive members shall receive $100 per day that the council meets, and their reasonably necessary traveling expenses while in the performance of their official duties.

HOUSE DOCKET, NO. 1831 FILED ON: 1/20/2011

HOUSE . . . . . No. 1221

The Commonwealth of Massachusetts

PRESENTED BY:

Michael A. Costello

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act improving access to coverage for Medicaid beneficiaries.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Michael A. Costello	*1st Essex*
Bradley H. Jones, Jr.	*20th Middlesex*

HOUSE . . . . . No. 1221

By Mr. Costello of Newburyport, a petition (accompanied by bill, House, No. 1221) of Michael A. Costello and Bradley H. Jones, Jr. relative to enrollment into MassHealth and Medicaid managed care organizations. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act improving access to coverage for Medicaid beneficiaries.

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

SECTION 1. Chapter 118E of the General Laws is hereby amended by adding the following new section:

Section 62 - The Executive Office of Health and Human Services shall discontinue membership in the MassHealth fee-for-service program and primary care clinician plan, and shall begin to enroll all members meeting eligibility requirements, as established pursuant to applicable federal and state law and regulation, into a Medicaid managed care organization that has contracted with the commonwealth to deliver such managed care services, in accordance with the enrollment and assignment process for other eligible categories and at the appropriate levels of premium.

SECTION 2.

This act shall take effect on January 1, 2013.

HOUSE DOCKET, NO. 1876 FILED ON: 1/20/2011

HOUSE . . . . . No. 1222

The Commonwealth of Massachusetts

PRESENTED BY:

Linda Dorcena Forry

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to streamlining administrative procedures.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Linda Dorcena Forry	*12th Suffolk*
James J. Dwyer	*30th Middlesex*
Harold P. Naughton, Jr.	*12th Worcester*
Benjamin Swan	*11th Hampden*

HOUSE . . . . . No. 1222

By Ms. Forry of Boston, a petition (accompanied by bill, House, No. 1222) of Linda Dorcena Forry and others relative to evidence of coverage to be delivered to covered adults by health, dental and vision care providers. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to streamlining administrative procedures.

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

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

SECTION 1. Section 12 of Chapter 176O of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by striking out subsections (b) and (c) and inserting in place thereof the following subsections:--

(b) A carrier or utilization review organization shall make a determination regarding the medical necessity of a proposed admission, procedure or service that requires a determination within two working days of obtaining all necessary information. For purposes of this section, "necessary information" shall include the results of any face-to-face clinical evaluation or second opinion that may be required. In the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization shall notify the provider rendering or requesting the service within 24 hours. In the case of an adverse determination, the carrier or

utilization review organization shall notify the provider rendering or requesting the service within 24 hours, and shall provide written or electronic confirmation of the notification to the insured and the provider within one working day thereafter.

(c) A carrier or utilization review organization shall make a concurrent review determination within one working day of obtaining all necessary information. In the case of a determination to approve an extended stay or additional services, the carrier or utilization review organization shall notify the provider rendering or requesting the service within one working day. In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering or requesting the service within 24 hours and shall provide written or electronic notification to the insured and the provider within one working day thereafter. The service shall be continued without liability to the insured until the insured has been notified of the determination.

SECTION 2. Subsection (a) of Section 6 of Chapter 176O of the General Laws, as so appearing in the 2006 Official Edition, is hereby amended by striking out clause (2) thereof.

HOUSE DOCKET, NO. 1970 FILED ON: 1/20/2011

HOUSE . . . . . No. 1225

The Commonwealth of Massachusetts

PRESENTED BY:

Michael F. Kane

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act concerning Medicaid and Accountable Care.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Michael F. Kane	*5th Hampden*
James T. Welch	*Hampden*

HOUSE . . . . . No. 1225

By Mr. Kane of Holyoke, a petition (accompanied by bill, House, No. 1225) of Michael F. Kane and James T. Welch relative to Medicaid and Accountable Care. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act concerning Medicaid and Accountable Care.

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

BE IT ENACTED:

1. a. The Office of Medicaid and the Executive Office of Health and Human Services (EOHHS) shall establish a three-year Medicaid urban-area accountable care organization (ACO) demonstration project as provided in this act. Urban ACOs approved for participation in the demonstration project shall be non-profit organizations formed through the voluntary participation of local hospitals, clinics, health centers, primary care physicians, nurses, and public health agencies for the purpose of improving the quality, capacity, and accessibility of the local health care system for Medicaid beneficiaries residing in the region. Payments for services reimbursed by the Medicaid fee-for-service program to providers participating in an approved urban ACO demonstration-project shall be made to the urban ACO and distributed to the participating providers in accordance with a written plan approved by the Office of Medicaid and EOHHS. The urban ACO demonstration project shall be developed in consultation with

managed care organizations and other vendors that contract with the Medicaid program to provide health care services to Medicaid beneficiaries.

b. In developing the written plan for distributing payments for services rendered to Medicaid patients by participating urban ACO demonstration project providers, the Office of Medicaid and EOHHS, shall consider payment methodologies that promote care-coordination through multi-disciplinary teams, including payment for care of patients with chronic diseases and the elderly, and that encourage services such as: (i) patient or family education for patients with chronic diseases; (ii) home-based services; (iii) telephonic communication; (iv) group care; and (v) culturally and linguistically appropriate care. In addition, the payment system shall be structured to reward quality and improved patient outcomes, particularly for high cost, high needs patients. The payment system may not increase costs to Medicaid for patients served by an ACO demonstration project beyond the benchmark cost of care for those patients if they were not served by an ACO.

c. Nothing in this act shall be construed to limit the choice of a Medicaid beneficiary to access care for family planning services or any other type of healthcare services from a qualified health care provider who is not participating in the urban ACO demonstration project.

d. The Office of Medicaid and EOHHS shall begin implementing the urban ACO demonstration project no later than July 1, 2011.

e. The Office of Medicaid and EOHHS may certify up to five urban ACOs for participation in shared savings programs that promote accountability for patient populations residing in a designated urban area. Each such shared savings program will be operated as an urban ACO demonstration project designed to coordinate the provision of health care items and services paid

for by Medicaid; to encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and facilitate the development of medical homes.

f. The Office of Medicaid and EOHHS shall certify the urban ACO for participation in the urban ACO demonstration project following its determination that the urban ACO meets the requirements of this act and is designed to improve quality, cost, and access to health care by Medicaid beneficiaries. Urban ACO demonstration project applicants must agree to be accountable for the quality, cost, and overall access to care of the Medicaid beneficiaries residing in the designated urban area for a period of no less than three years. For purposes of this act, "designated urban area" shall mean a municipality or defined geographic area in which no fewer than 5,000 Medicaid beneficiaries reside, or other threshold that the Office of Medicaid and EOHHS determine to be sufficient for reliable measurement of realized savings. EOHHS, in consultation with the Office of Medicaid, shall adopt regulations establishing additional criteria required for participation in the urban ACO demonstration project.

g. An urban ACO demonstration project applicant must demonstrate that it is a non-profit entity that has established a mechanism for shared governance. The urban ACO must have a formal legal structure that allows the urban ACO to receive payments from Medicaid and any voluntarily participating Medicaid managed care organizations and distributes payments for quality improvement and for shared savings to participating ACO providers. Before receiving payments, the urban ACO must submit a written demonstration project application for review and approval by the Office of Medicaid and EOHHS on how the payments will be used to improve quality, expand access, and reduce cost for patients living in geographic region of the ACO.

h. The Medicaid fee-for-service program shall remit payment to the participating urban ACO after approval by the Office of Medicaid and EOHHS of the ACO's written demonstration project application for use of the funds and determination of the shared savings payment and approved by the Office of Medicaid and EOHHS using the methodology developed under Section 1(b) above.

i. The benchmark, against which savings are measured for each urban ACO, once established, may only be changed once every three years. A portion of realized shared savings from the urban ACOs may be used to offset increased health care expenditures by the Commonwealth of Massachusetts and support the continued operation of this urban ACO demonstration project. The percentage of shared savings to be (i) distributed to the urban ACO; (ii) kept by a participating Medicaid managed care organization or other third party payer; and (iii) kept by the Commonwealth of Massachusetts to support the administration of the program shall be determined at the start of the demonstration project and every three years.

j. The percentage-of shared savings to be distributed or kept as described herein shall be configured to: (i) ensure widespread participation by both urban communities and payers; (ii) ensure that the Commonwealth of Massachusetts realizes meaningful savings; and (iii) ensure that the demonstration project's annual administrative costs can be covered by year three.

k. As used in this act:

"Primary care provider" includes, but is not limited to, a primary care physician, a registered nurse, a primary care professional medical practice, a federally qualified or community health center, and a primary care outpatient clinic operated by a general hospital.

2. The Office of Medicaid shall, with assistance from EOHHS, evaluate the urban ACO demonstration project annually to assess: whether cost savings are achieved through implementation of the urban ACO demonstration project; the rates of health screening; the outcomes and hospitalization rates for persons with chronic illnesses, and the hospitalization and readmission rates for the frail elderly.

3. The Secretary of EOHHS shall apply for such State plan amendments or waivers as may be necessary to implement the provisions of this act and to secure federal financial participation for State Medicaid expenditures under the federal Medicaid program. The Secretary of EOHHS may apply for participation in federal ACO demonstration projects that align with the goals of this act.

4. The Secretary of EOHHS shall report annually to the Governor, and to the Legislature, on the findings and recommendations of the urban ACO demonstration project. After three years, if the Secretary of EOHHS finds the urban ACO demonstration project was successful in reducing cost and improving the quality of care for Medicaid beneficiaries, the urban ACO demonstration project may be expanded to include additional underserved communities and shall become a permanent program.

5. The Secretary of EOHHS shall adopt such rules and regulations as the commissioners deem necessary to carry out the provisions of this act.

6. This act shall take effect upon enactment and shall expire three years after the effective date, but the Director of the Office of Medicaid and the Secretary of EOHHS may take such

anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

HOUSE DOCKET, NO. 1680 FILED ON: 1/20/2011

HOUSE . . . . . No. 1236

The Commonwealth of Massachusetts

PRESENTED BY:

Harriett L. Stanley

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to MassHealth managed care.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Harriett L. Stanley	*2nd Essex*

HOUSE . . . . . No. 1236

By Ms. Stanley of West Newbury, a petition (accompanied by bill, House, No. 1236) of Harriett L. Stanley relative to the transfer of certain members into a health maintenance organization. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to MassHealth managed care.

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

SECTION 1. Chapter 118E of the General Laws is hereby amended by inserting after section 62 the following section: -

Section 63. Notwithstanding any general or special law to the contrary, MassHealth shall begin to transfer all eligible members of the primary care clinician/mental health and substance abuse plan into a health maintenance organization under contract, where 30% of the eligible enrollees shall be transferred before the end of FY2012, 40% shall be transferred by the end of FY2013 and the remaining 30% shall be transferred by the end of FY2014 pursuant to applicable federal law and regulations. Health maintenance organizations under contract shall bid-out behavioral health services, using the clinical specifications currently utilized by the primary care clinician/mental health and substance abuse plan.

HOUSE DOCKET, NO. 1878 FILED ON: 1/20/2011

HOUSE . . . . . No. 1237

The Commonwealth of Massachusetts

PRESENTED BY:

Harriett L. Stanley

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act Relative to Containing Health Care Costs in the Commonwealth.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Harriett L. Stanley	*2nd Essex*

HOUSE . . . . . No. 1237

By Ms. Stanley of West Newbury, a petition (accompanied by bill, House, No. 1237) of Harriett L. Stanley relative to containing health care costs. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act Relative to Containing Health Care Costs in the Commonwealth.

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

SECTION 1. Chapter 118E of the General Laws is hereby amended by inserting after section 62 the following section: -

Section 63. Notwithstanding any general or special law to the contrary, MassHealth shall transfer all eligible members of the primary care clinician/mental health and substance abuse plan into a health maintenance organization under contract before the end of FY2012 pursuant to applicable federal law and regulations.

HOUSE DOCKET, NO. 1984 FILED ON: 1/20/2011

HOUSE . . . . . No. 1240

The Commonwealth of Massachusetts

PRESENTED BY:

Harriett L. Stanley

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to sustainable health care cost containment.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Harriett L. Stanley	*2nd Essex*

HOUSE . . . . . No. 1240

By Ms. Stanley of West Newbury, a petition (accompanied by bill, House, No. 1240) of Harriett L. Stanley relative to sustainable health care cost containment. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to sustainable health care cost containment.

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

SECTION 1. Chapter 118E of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following new section:

Section 62. ¬ The Executive Office of Health and Human Services shall discontinue membership in the MassHealth fee-for-service program and primary care clinician plan, and for plan years beginning on or after January 1, 2011, shall begin to enroll all members meeting eligibility requirements, as established pursuant to applicable federal and state law and regulation, into a Medicaid managed care organization that has contracted with the commonwealth to deliver such managed care services, in accordance with the enrollment and assignment process for other eligible categories and at the appropriate levels of premium.

SECTION 2. Notwithstanding any general or special law to the contrary, the Executive Office of Health and Human Services shall move away from fee for service payment to all providers of medical care or services for which medical assistance and medical benefits are available under Chapter 118E. In accordance with the recommendations of the Special Commission on Payment

Reform created pursuant to Section 44 of Chapter 305 of the Acts of 2008 and any subsequent commission on payment reform, any medical assistance provided under Chapter 118E shall be reimbursed by a global capitation payment or other payment that demonstrates lower payments for more coordinated and efficient care. The Secretary shall provide an annual report to the house and senate committee on ways and means and the joint committee on health care financing on or before December 31st outlining in detail the changes that have been made to date and the savings that have resulted.

HOUSE DOCKET, NO. 1809 FILED ON: 1/20/2011

HOUSE . . . . . No. 1498

The Commonwealth of Massachusetts

PRESENTED BY:

Jason M. Lewis

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act to promote prevention and wellness through a public health trust.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Brian M. Ashe	*2nd Hampden*
James B. Eldridge	*Middlesex and Worcester*
Jonathan Hecht	*29th Middlesex*
Louis L. Kafka	*8th Norfolk*
Stephen Kulik	*1st Franklin*
Carl M. Sciortino, Jr.	*34th Middlesex*
Benjamin Swan	*11th Hampden*

HOUSE . . . . . No. 1498

By Mr. Lewis of Winchester, a petition (accompanied by bill, House, No. 1498) of Brian M. Ashe and others for legislation establishing a fund to be known as the prevention and cost control trust fund. Public Health.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act to promote prevention and wellness through a public health trust.

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

SECTION 1. Chapter 111 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 2F the following section:–

Section 2G. (a) There shall be established upon the books of the commonwealth a separate fund to be known as the Prevention and Cost Control Trust Fund to be expended, without further appropriation, by the department of public health. The fund shall consist of all prevention and cost control surcharge revenues collected by the commonwealth in accordance with the provisions of subsection (g) of section 38 of chapter 118G, public and private sources such as gifts, grants and donations to further community-based prevention activities and interest earned on such revenues; provided, however, that this provision shall not preclude the appropriation from the General Fund of the commonwealth of additional amounts to support the administration of the fund.

The commissioner of the department of public health, as trustee, shall administer the fund. The commissioner, in consultation with the Prevention and Cost Control Advisory Board established in subsection (c), shall make expenditures from this account consistent with the provisions of subsection (d); provided, that no more than 20 percent of the amounts held in the fund in any one year shall be used by the department for program administration, technical assistance to grantees, or program evaluation.

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

(c) There shall be a Prevention and Cost Control Advisory Board constituted for the general purpose of making recommendations to the commissioner concerning the administration and allocation of the fund, establishing evaluation criteria, and performing any other functions specifically granted to it by law.

The board shall consist of 13 members who shall be appointed by the governor, including the following members: the commissioner of the department of public health, who shall serve as chair of the board; the commissioner of the division of health care finance and policy or a designee; the secretary of the executive office of health and human services or a designee; a representative with expertise in the field of public health economics; a representative with expertise in public health research; a representative with expertise in the field of health equity; a representative from a local board of health for a city with population greater than 50,000; a representative of a board of health with a population under 50,000; a representative from the health insurance industry; a representative from a consumer health organization; a representative

from a hospital association; a representative from a statewide public health organization and a representative from an accountable care organization.

The board shall annually publish a report to be used by the commissioner in determining allocation of funds. Said report shall include but not be limited to the following: (i) a list of the most prevalent preventable health conditions in the commonwealth, including health disparities experienced by populations based on race, ethnicity, gender, disability status, sexual orientation, or socio-economic status; (ii) a list of the most costly preventable health conditions in the commonwealth; (iii) a list of evidence-based or promising community-based interventions related to the conditions identified in (i) and (ii). Where appropriate, the report shall reference goals and best practices established by the national prevention and public health promotion council and the centers for disease control and prevention, including, but not limited to the national prevention strategy, the healthy people report and the community prevention guide.

(d) The commissioner shall annually award no less than 80 percent of the fund through a competitive grant process to municipalities and community-based organizations that apply for the implementation, evaluation, and dissemination of evidence-based community preventive health activities, with a preference for activities that, based on findings of the board, will reduce rates of the most prevalent and costly preventable health conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming. To be eligible to receive a grant under this subsection, a recipient shall be: (i) a municipality or group of municipalities working in collaboration, or (ii) a community-based organization working in collaboration with one or more municipalities. Expenditures from the fund for such purposes shall complement and not replace existing local, state, or federal public health-related funding.

(e) Funding shall be allocated approximately proportionally by population to the 5 healthy communities regions in the commonwealth as designated by the department of public health; provided that no region shall receive less than 10 percent of the sum of annually allocated funds directed to all regions.

(f) The department shall conduct an evaluation of funded activities on a yearly basis, consistent with goals and criteria that may be established by the prevention and cost control advisory board.

(g) The commissioner shall report annually on March 1 to the house and senate committees on ways and means and the joint committee on public health: (i) the revenue credited to the fund; (ii) the amount of fund expenditures that are attributable to the administrative costs of the department; (iii) an itemized list of the funds expended through grants and a description of the grantee activities; and (iv) the results of evaluation of the effectiveness of the activities funded through grants. The report shall be made available to the public.

SECTION 2. Section 38 of chapter 118G of the General Laws is hereby amended by inserting after subsection (f) the following subsection:–

(g) (1) In addition to the surcharge assessed under subsection (a), acute hospitals and ambulatory surgical centers shall assess a prevention and cost control surcharge on all payments subject to surcharge as defined in section 34. The prevention and cost control surcharge amount shall equal the product of (i) the prevention and cost control surcharge percentage and (ii) amounts paid for these services by a surcharge payor. The division shall calculate the prevention and cost control surcharge percentage by dividing $75,000,000 by the projected annual aggregate payments subject to the surcharge, excluding projected annual aggregate payments based on payments made by managed care organizations. The division shall determine the prevention and cost

control surcharge percentage before the start of each fund fiscal year and may redetermine the prevention and cost control surcharge percentage before April 1 of each fund fiscal year if the division projects that the initial prevention and cost control surcharge established the previous October will produce less than $70,000,000 or more than $80,000,000. Before each succeeding October 1, the division shall redetermine the prevention and cost control surcharge percentage incorporating any adjustments from earlier years. In each determination or redetermination of the prevention and cost control surcharge percentage, the office shall use the best data available as determined by the division and may consider the effect on projected prevention and cost control surcharge payments of any modified or waived enforcement under subsection (e). The division shall incorporate all adjustments, including, but not limited to, updates or corrections or final settlement amounts, by prospective adjustment rather than by retrospective payments or assessments.

(2) Prevention and cost control surcharge payments shall be deposited in the Prevention and Cost Control Trust Fund, established in section 2G of chapter 111.

(3) All provisions of subsections (a) to (f) and section 34 shall apply to the prevention and cost control surcharge, to the extent not inconsistent with the provisions of this subsection.

SECTION 3. Notwithstanding any general or special law to the contrary, the prevention and cost control advisory board shall undertake a review of the funding mechanism by which the prevention and cost control trust fund is funded. This review shall include, but not be limited to an analysis of whether the amount of funding remains adequate and whether the funding mechanism should be altered to account for changes in the health care payment system. Said

report shall be filed with the house and senate committees on ways and means and the joint committee on public health, no later than March 1, 2014.

HOUSE DOCKET, NO. 2030 FILED ON: 1/20/2011

HOUSE . . . . . No. 2081

The Commonwealth of Massachusetts

PRESENTED BY:

Thomas P. Conroy

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act creating an all-payer claims database review committee and designating DHCFP as sole repository of health care claims data.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Thomas P. Conroy	*13th Middlesex*
David B. Sullivan	*6th Bristol*

HOUSE . . . . . No. 2081

By Mr. Conroy of Wayland, a petition (accompanied by bill, House, No. 2081) of Thomas P. Conroy and David B. Sullivan creating an all-payer claims database review committee and designating the Division of Health Care Finance and Policy as sole repository of health care claims data. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act creating an all-payer claims database review committee and designating DHCFP as sole repository of health care claims data.

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

SECTION 1.

Chapter 118G of the General Laws is hereby amended by inserting after section 5 the following new section:

Section 6. (a). There shall be established a reviewing committee to govern the administration of the division's all-payer claims data base. The reviewing committee shall be comprised of representatives from the hospital, health plan and provider communities, and shall include, but not be limited to the following: a representative of the Massachusetts Hospital Association, a representative of Blue Cross and Blue Shield of Massachusetts, a representative of the Massachusetts Association of Health Plans, and a representative of the Massachusetts Medical Society. The reviewing committee shall be responsible for advising the division on the standards

for release and use of the data submitted, and shall ensure that such standards protect patient privacy, and guard against utilization of the data for the purpose of anti-competitive behavior.

(b) The division shall promulgate such regulations as may be necessary to ensure the uniform reporting of revenues, charges, costs and utilization of health care services delivered by institutional and non-institutional providers. Such uniform reporting shall enable the division to identify, on a patient-centered and provider-specific basis, statewide and regional trends in the cost, availability and utilization of medical, surgical, diagnostic and ancillary services provided by acute hospitals, nursing homes, chronic care and rehabilitation hospitals, other specialty hospitals, clinics, including mental health clinics, and such ambulatory care providers as the division may specify.

In addition, such uniform reporting shall provide the name and address and such other identifying information as may be needed relative to the employer of any patient for whom health care services were rendered under this chapter and for whom reimbursement from the uncompensated care pool or the Health Safety Net Trust Fund has been requested.

The division may promulgate regulations necessary to ensure the uniform reporting of information from private and public health care payers that enables the division to analyze: (i) changes over time in health insurance premium levels; (ii) changes in the benefit and cost-sharing design of plans offered by these payers; and (iii) changes in measures of plan cost and utilization; provided that this analysis shall facilitate comparison among plans and between public and private payers.

The division shall ensure the timely reporting of information required under this section. The division shall notify payers of any applicable reporting deadlines. The division may assess

penalties against any private health care payer that fails to meet a reporting deadline. The division shall notify, in writing, a private health care payer that it has failed to meet a reporting deadline and that failure to respond within 2 weeks of the receipt of the notice may result in penalties. A payer that fails, without just cause, to provide the requested information within 2 weeks following receipt of the written notice required under this paragraph may be assessed a penalty of up to $1,000 per week for each week of delay after the 2 week period following the payer's receipt of the written notice; provided, however, that the maximum annual penalty against a private payer under this section shall be $50,000. Amounts collected pursuant to this section shall be deposited in the General Fund.

The division shall require the submission of data and other information from each private health care payer offering small or large group health plans including, but not limited to: (i) average annual individual and family plan premiums for each payer's most popular plans for a representative range of group sizes, as further determined in regulations and average annual individual and family plan premiums for the lowest cost plan in each group size that meets the minimum standards and guidelines established by the division of insurance under section 8H of chapter 26; (ii) information concerning the actuarial assumptions that underlie the premiums for each plan; (iii) summaries of the plan designs for each plan; (iv) information concerning the medical and administrative expenses, including medical loss ratios for each plan, using a uniform methodology, and collected under section 21 of chapter 176O; (v) information concerning the payer's current level of reserves and surpluses; (vi) information on provider payment methods and levels; (vii) health status adjusted total medical expenses by provider group and local practice group and zip code calculated according to a uniform methodology; (viii) relative prices paid to every hospital, physician group, ambulatory surgical center, freestanding imaging center,

mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider and calculated according to a uniform methodology; and (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology.

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

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

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

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

With respect to any acute or non-acute hospital, the division shall, by regulation, designate information necessary to effect the purposes of this chapter including, but not be limited to, the filing of a charge book, the filing of cost data and audited financial statements and the submission of merged billing and discharge data. The division shall, by regulation, designate

standard systems for determining, reporting and auditing volume, case-mix, proportion of low income patients and any other information necessary to effectuate the purposes of this chapter and to prepare reports comparing acute and non-acute care hospitals by cost, utilization and outcome. Such regulations may require such hospitals to file required information and data by electronic means; provided, however, that the division shall allow reasonable waivers from such requirement. The division shall, at least annually, publish a report analyzing such comparative information for the purpose of assisting third-party payers and other purchasers of health services in making informed decisions. Such report shall include comparative price and service information relative to outpatient mental health services.

When collecting information or compiling reports intended to compare individual health care providers, the commission shall require that:

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

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

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

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

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

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

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

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

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

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

(k) providers shall be reimbursed for the reasonable costs that are required for assembling, formatting and transmitting data and information to organizations that develop or disseminate provider profiles; and

(l) the benefits of provider profiling shall outweigh the costs of developing and disseminating the profiles.

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

The division shall ensure that health care providers and payors that supply the data are not charged any administrative fees for access to the data in accordance with the division's requirements for protecting patient privacy, and guarding against utilization of the data for the purpose of anti-competitive behavior.

SECTION 2. Chapter 6A of the General Laws is hereby amended by adding after section 16, the following new language:

16A. Health Care Claims Data

The division of health care finance and policy shall be the sole repository for health care data collected pursuant to Section 6 of Chapter 118G. All other agencies, authorities, councils, boards, and commissions of the commonwealth seeking health care data that is collected by the division shall utilize such data prior to requesting any data from health care providers and payers. The division may enter into interagency services agreements for transfer and use of the data.

HOUSE DOCKET, NO. 2429 FILED ON: 1/20/2011

HOUSE . . . . . No. 2084

The Commonwealth of Massachusetts

PRESENTED BY:

John P. Fresolo

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act to promote health care cost containment through select and tiered network plans.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
John P. Fresolo	*16th Worcester*

HOUSE . . . . . No. 2084

By Mr. Fresolo of Worcester, a petition (accompanied by bill, House, No. 2084) of John P. Fresolo for legislation to promote health care cost containment through select and tiered network plans. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act to promote health care cost containment through select and tiered network plans.

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

SECTION 1. Section 9A of chapter 176O of the General Laws, as created by Chapter 288 of the Acts of 2010, is hereby amended by striking out subsection (a), and replacing it with the following:-

(a) (i) limits the ability of the carrier to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation; (ii) requires the carrier to place all members of a provider group, whether local practice groups or facilities, in the same tier of a tiered network plan; or (iii) requires the carrier to include all members of a provider group, whether local practice groups or facilities, in a select network plan on an all-or-nothing basis; or

HOUSE DOCKET, NO. 2430 FILED ON: 1/20/2011

HOUSE . . . . . No. 2085

The Commonwealth of Massachusetts

PRESENTED BY:

John P. Fresolo

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act to improve affordability of health care.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
John P. Fresolo	*16th Worcester*

HOUSE . . . . . No. 2085

By Mr. Fresolo of Worcester, a petition (accompanied by bill, House, No. 2085) of John P. Fresolo for legislation to improve affordability of health care. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act to improve affordability of health care.

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

SECTION 1. Chapter 29 of the General Laws is hereby amended by inserting after section 2BBBB the following section:

Section 2CCCC. There shall be established and set up on the books of the commonwealth a separate fund to be known as the High Risk Reinsurance Trust Fund. The commissioner of insurance, in consultation with the commissioner of health care finance and policy, the secretary of administration and finance and the secretary of health and human services, shall administer a reinsurance program for high-risk individuals covered under products issued under chapter 176J. The commissioner of the division of health care finance and policy shall approve the amounts assessed on payers sufficient to fund the level of reinsurance specified in section 14 of chapter 176J provided that to the extent federal financial participation is received, the commissioner shall adjust the amount assessed accordingly. The commissioner of the division of health care finance and policy shall promulgate regulations specifying the dates for collection and the method for

collecting the amount specified, provided however that the methodology must be through a surcharge mechanism consistent with section 38 of chapter 118G.

The commissioner of insurance shall appoint 7 representatives of carriers issuing or renewing products in accordance with said chapter 176J to be a members of a board to develop a plan of operations of such high-risk reinsurance program and to monitor the functioning of the program. The commissioner of insurance, in consultation with the secretary of administration and finance and the secretary of health and human services, shall approve the plan of operations of the reinsurance program, the level of reinsurance sponsored by the program, any premium charged for reinsurance, the manner by which expenditures shall be made from the fund to reimburse carriers, as defined section 1 of said chapter 176J, for all costs that the carriers may incur in claims under section 14 of said chapter 176J and the level of assessments necessary to pay for costs that are not covered by any reinsurance premiums.

Nothing in this section shall prohibit the commissioner of insurance from contracting with a third party to administer the fund.

The commissioner of insurance shall adopt regulations as necessary to implement this section. The commissioner of insurance shall, not later than October 1 of each year, file a written, detailed report on the reinsurance program with the joint committee on health care financing, the joint committee on financial services and the house and senate committees on ways and means specifying:

(i) the methodology and mechanism used in ascertaining any assessments; (ii) the methodology used for reimbursing eligible carriers; and (iii) the disbursements made by carriers and the amount of those disbursements for the fiscal year ending on the preceding June 30.

SECT1ON 2. Chapter 176J of the General Laws is hereby amended by adding the following section:-

Section 14. (a) The commissioner shall reimburse a carrier an amount equal to 90 per cent of claims costs in any calendar year between the reinsurance threshold and the reinsurance limit attributable to any eligible individual or eligible employee or dependent of an eligible small business. The initial reinsurance threshold shall be $100,000. The initial reinsurance limit shall be $2,000,000. The commissioner shall increase the reinsurance threshold and limit on an annual basis by an amount consistent with medical cost trends in the small group market.

(b) A carrier's cost and utilization trends applicable to premiums charged to eligible small businesses shall reflect anticipated reimbursements pursuant to this section.

(c) Reimbursements to carriers pursuant to this section shall be made from the Individual Group Reinsurance Fund established in section 2CCCC of chapter 29.

(d) The commissioner shall promulgate regulations necessary to implement this section.

HOUSE DOCKET, NO. 2909 FILED ON: 1/21/2011

HOUSE . . . . . No. 2093

The Commonwealth of Massachusetts

PRESENTED BY:

Louis L. Kafka

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act reducing health care cost trends.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Louis L. Kafka	*8th Norfolk*

HOUSE . . . . . No. 2093

By Mr. Kafka of Stoughton, a petition (accompanied by bill, House, No. 2093) of Louis L. Kafka for legislation to require a determination of need prior to substantial capital expenditures for the construction of health care facilities. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act reducing health care cost trends.

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

SECTION 1. Section 25C of Chapter 111 of the General Laws is hereby amended by striking the first paragraph and inserting in place thereof the following:

Section 25C. Notwithstanding any contrary provisions of law, except as provided in section twenty-five C1/2, no person or agency of the commonwealth or any political subdivision thereof shall make substantial capital expenditures for construction of a health care facility or substantially change the service of such facility unless there is a determination by the department that there is need therefore, followed by review and approval by the Attorney General of the Commonwealth, pursuant to Section 11M of Chapter 12 . No such determination of need shall be required for any substantial capital expenditure for construction or any substantial change in service which shall be related solely to the conduct of research in the basic biomedical or applied medical research areas, and shall at no time result in any increase in the clinical bed capacity or outpatient load capacity of a health care facility, and shall at no time be included within or cause an increase in the gross patient service revenue of a facility for health care services, supplies, and

accommodations, as such revenue shall be defined from time to time in accordance with section thirty-one of chapter six A. Any person undertaking any such expenditure related solely to such research which shall exceed or may reasonably be regarded as likely to exceed one hundred and fifty thousand dollars or any such change in service solely related to such research, shall give written notice thereof to the department and the division of health care finance and policy at least sixty days before undertaking such expenditure or change in service. Said notice shall state that such expenditure or change shall be related solely to the conduct of research in the basic biomedical or applied medical research areas, and shall at no time be included within or result in any increase in the clinical bed capacity or outpatient load capacity of a facility, and shall at no time cause an increase in the gross patient service revenue, as defined in accordance with said section thirty-one of said chapter six A, of a facility for health care services, supplies and accommodations. Notwithstanding the preceding three sentences, a determination of need shall be required for any such expenditure or change if the notice required by this section is not filed in accordance with the requirements of this section, or if the department finds, within sixty days after receipt of said notice, that such expenditure or change will not be related solely to research in the basic biomedical or applied medical research areas, or will result in an increase in the clinical bed capacity or outpatient load capacity of a facility, or will be included within or cause an increase in the gross patient service revenues of a facility. A research exemption granted under the provisions of this section shall not be deemed to be as evidence of need in any determination of need proceeding.

SECTION 2. Chapter 12 of the General Laws is hereby amended by inserting after Section 11L the following new section:

Section 11M: (a) The Attorney General shall have jurisdiction to review all applications for Determination of Need filed pursuant to Section 25C of Chapter 111. Following initial approval by the Department of Public Health, all Determination of Need applications shall be sent to the Office of the Attorney General for review and approval.

(b) The Attorney General shall approve a project only if the Attorney General determines that the project will not have an adverse effect on competition in the health care market and shall give due consideration to whether the project is likely to increase rates of payment to providers, whether the project is likely to result in an inappropriate increase in utilization of health care services, and whether the proposed service could be provided by a community based provider.

(c) The Attorney General shall report to the Department of Public Health the results of said review no later than four months after receiving notice of approval by the Department. No project shall be approved by the Department of Public Health without approval of the Attorney General.

HOUSE DOCKET, NO. 2325 FILED ON: 1/20/2011

HOUSE . . . . . No. 2098

The Commonwealth of Massachusetts

PRESENTED BY:

Joyce A. Spiliotis

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to the electronic submission of claims.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Joyce A. Spiliotis	*12th Essex*

HOUSE . . . . . No. 2098

By Ms. Spiliotis of Peabody, a petition (accompanied by bill, House, No. 2098) of Joyce A. Spiliotis relative to the electronic submission of health care claims. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to the electronic submission of claims.

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

SECTION 1. Section 108 of Chapter 175 of the General Laws, as appearing in the Official Edition, is hereby amended by striking out subsection 4(c) and inserting in place thereof the following:

4(c). Within fifteen days after an insurer's receipt of notice of claim by a claimant or provider under a policy of accident and sickness insurance which is delivered or issued for delivery in the commonwealth, and which provides hospital expense, medical expense, surgical expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the

rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud. Beginning on January 1, 2006, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 2. Section 110 of Chapter 175 of the General Laws, as appearing in the Official Edition, is hereby amended by striking out subsection (G) and inserting in place thereof the following:

(G) For purposes of this section the term ""notice of a claim" shall mean any notification whether in writing or otherwise, to an insurer or its authorized agent, by any person, firm, association, or corporation asserting right to payment under a policy of insurance which reasonably apprises the insurer of the existence of a claim.

Within fifteen days after an insurer's receipt of notice of claim by a claimant under a general or blanket policy of accident and sickness insurance which is delivered or issued for delivery in the commonwealth, and which provides hospital expense, medical expense, surgical expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The

provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 3. Chapter 176G of the General Laws, as appearing in the Official Edition, is hereby amended by striking out section 6 and inserting in place thereof the following:

Section 6. A health maintenance organization may enter into contractual arrangements with any other person or company for the provision, to the health maintenance organization, of health services, insurance, reinsurance and administrative, marketing, underwriting or other services on a nondiscriminatory basis. A health maintenance organization shall not refuse to contract with or compensate for covered services an otherwise eligible provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's products as they relate to the needs of such provider's patients. No contract between a participating provider of health care services and a health maintenance organization shall be issued or delivered in the commonwealth unless it contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the provider of health care services, the health maintenance organization shall (i) make payments for such services provided, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the health maintenance organization fails to comply with this paragraph for any claims related to the provision of health care services, said health maintenance organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the health maintenance organization's

receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the health maintenance organization is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 4. Chapter 176I of the General Laws, as appearing in the Official Edition, is hereby amended by striking section 2 and inserting in place thereof the following:

Section 2. An organization may enter into a preferred provider arrangement with one or more health care providers upon a determination by the commissioner that the organization and the arrangement comply with the requirements of this chapter and the regulations hereunder. An organization shall not condition its willingness to allow any health care provider to participate in a preferred provider arrangement on such health care provider's agreeing to enter into other contracts or arrangements with the organization that are not part of or related to such preferred provider arrangements. An organization shall not refuse to contract with or compensate for covered services an otherwise eligible participating or nonparticipating provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's products as they relate to the needs of such provider's patients. An organization shall submit information concerning any proposed preferred provider arrangements to the commissioner for approval in accordance with regulations promulgated by the commissioner. Said regulations shall comply with the applicable provisions of chapter thirty A of the General Laws. Said information shall include at least the following: (a) a description of the health services and any other benefits to which the covered person is entitled; (b) a description of the locations where and the manner

in which health services and other benefits may be obtained; (c) a copy of the evidence of coverage; (d) copies of any contracts with preferred providers; (e) a description of the rating methodology and rates. The arrangement shall meet the following standards: (a) Standards for maintaining quality health care, including satisfying any quality assurance regulations promulgated by any state agency; (b) Standards for controlling health care costs; (c) Standards for assuring reasonable levels of access of health care services and an adequate number and geographical distribution of preferred providers to render those services; (d) Standards for assuring appropriate utilization of health care service; and (e) Other standards deemed appropriate by the commissioner.

No organization may enter into a preferred provider arrangement with one or more health care providers unless said written arrangement contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the health care provider, the organization shall (i) make payments for the provision of such services, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the organization fails to comply with the provisions of this paragraph for any claims related to the provision of health care services, said organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the organization is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

HOUSE DOCKET, NO. 2981 FILED ON: 1/21/2011

HOUSE . . . . . No. 2100

The Commonwealth of Massachusetts

PRESENTED BY:

Harriett L. Stanley

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to an affordable health plan.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Harriett L. Stanley	*2nd Essex*

HOUSE . . . . . No. 2100

By Ms. Stanley of West Newbury, a petition (accompanied by bill, House, No. 2100) of Harriett L. Stanley relative to affordable health care in the Commonwealth. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 HOUSE
 , NO. *4331* OF 2009-2010.]

The Commonwealth of Massachusetts

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In the Year Two Thousand Eleven

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An Act relative to an affordable health plan.

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

SECTION 1. Chapter 176J of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following section:-

Section 11. As used in this section, the following words shall have the following meanings:

"Statutory reimbursement rate," with respect to payment to a health care provider for services rendered to any person covered under an "Affordable Health Plan", 110 percent of the Medicare reimbursement rate for those services as if they were rendered to a Medicare beneficiary not taking into consideration any beneficiary cost sharing. For services or supplies for which there is no Medicare reimbursement amount, the amount as determined by the commissioner of the division of health care finance and policy is to be consistent with Medicare payment policies at a 110 percent level and set in consultation with the commissioner of insurance.

(a) As a condition of doing business in the commonwealth, a carrier that offers health benefit plans to eligible small businesses and eligible individuals, as defined by chapter 176J, shall offer an "Affordable Health Plan" to all eligible individuals and small businesses, both within the connector, for such carriers participating in the connector, and for all such carriers outside the connector. This "Affordable Health Plan" shall contain benefits that are actuarially equivalent to the lowest level benefit plan available to the general public within the connector, other than the young adult plan. Payment for all services, other than outpatient pharmacy benefits, for all providers under "Affordable Health Plans" shall be consistent with the requirements as included in paragraph (b).

(b) Claims for services shall be adjudicated at the in-network benefit level or, if applicable under the terms of the plan, the out-of-network benefit level based on the participation status of the provider in the carrier's network. Every health care provider licensed in the commonwealth which provides covered services to a person covered under "Affordable Health Plans" must provide such service to any such person, as a condition of their licensure, and must accept payment at the lowest of the statutory reimbursement rate, an amount equal to the actuarial equivalent of the statutory reimbursement rate, or the applicable contract rate with the carrier for the carrier's product offering with the lowest level benefit plan available to the general public within the connector, other than the young adult plan, and may not balance bill such person for any amount in excess of the amount paid by the carrier pursuant to this section, other than applicable co-payments, co-insurance and deductibles.

(c) Providers shall not attempt to recoup such excess amounts by increasing charges to other health benefit plans or other payers. The division of health care finance and policy shall monitor provider charges to ensure compliance with this section and shall report any non-compliance to

the attorney general. The division of health care finance and policy shall promulgate regulations enforcing this subsection, which shall include penalties for noncompliance.

(d) Existing contracts between providers and carriers shall comply with the requirements of this section as to the reimbursement rate and providers shall provide services to individuals under "Affordable Health Plans" under such existing contracts with carriers. A provider that participates in a carrier's network or any health benefit plan shall not refuse to participate in the carrier's network with respect to the "Affordable Health Plan".

SECTION 2. Section 11 of Chapter 176J is hereby repealed.

SECTION 3. Section 2 of this act shall take effect on January 1, 2013.

HOUSE DOCKET, NO. 3209 FILED ON: 1/21/2011

HOUSE . . . . . No. 2781

The Commonwealth of Massachusetts

PRESENTED BY:

Jeffrey Sánchez

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act directing MassHealth to establish a chronic care improvement demonstration project.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Jeffrey Sánchez	*15th Suffolk*
Jason M. Lewis	*31st Middlesex*
William N. Brownsberger	*Second Suffolk and Middlesex*

HOUSE . . . . . No. 2781

By Mr. Sánchez of Boston, a petition (accompanied by bill, House, No. 2781) of Jeffrey Sánchez, Jason M. Lewis and William N. Brownsberger for legislation directing MassHealth to establish a chronic care improvement demonstration project. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act directing MassHealth to establish a chronic care improvement demonstration project.

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

SECTION 1. (a)Notwithstanding any general or special law to the contrary, the office of Medicaid, subject to appropriation and the availability of federal financial participation, and in consultation with the MassHealth payment policy advisory board, shall establish a chronic care improvement demonstration project. Within the chronic care improvement demonstration, the office shall solicit the participation of physician group practices, hospitals, or integrated delivery systems which meet the terms, conditions, and eligibility standards for participations in subsection (c) and (d) to provide practice-based care management to high-cost beneficiaries with multiple chronic illnesses through the utilization of nurse case managers integrated into physician-based primary care practices.

(b) The office shall establish a method for identifying eligible beneficiaries who may benefit from participation in a chronic care improvement program, provided, that beneficiaries shall have a high level of disease severity as indicated by Hierarchical Condition Categories scores and high health care costs and utilization of services based on claims data from the calendar year

prior to enrollment in the project. The office shall utilize a population-based intent-to-treat model to enroll eligible beneficiaries into control and treatment populations. Beneficiary participation will be voluntary, and may terminate participation at any time. Beneficiary participation will not change the amount, duration or scope of a participating beneficiary's traditional benefits. Eligible beneficiaries shall not be charged an additional fee for participation in chronic care improvement program.

(c) The office shall enter into three-year contracts with selected physician group practices, hospitals, or integrated delivery systems (participants) that provide for the payment of care to eligible beneficiaries utilizing a fee-at-risk payment methodology that includes a negotiated per-beneficiary-per-month management fee and pay-for-performance payments based on quality measures as determined by the office. In addition to terms and conditions deemed necessary by the office, all contracts shall require selected participants to (i) achieve a minimum 2 percent net savings in MassHealth costs for the treatment population as compared to the MassHealth costs for the control group plus the sum total of beneficiary-per-month management fees and pay-for-performance payments (ii) provide for adjustments in payment rates to a participant insofar as the office determines that the participant failed to meet the performance standards specified in the contract (iii) monitor and report to the office, in a manner specified by the office, on health care quality, cost, utilization of services, and outcomes (iv) meet the eligibility standards for participations in subsection (d).

(d) (1) To be eligible to submit a request for participation in the chronic care improvement demonstration project, a physician group practice, hospital, or integrated delivery system must demonstrate to the office that it possesses sufficient resources to (i) provide an enhanced level of care to eligible beneficiaries to reduce cost as well as improve quality of care and quality of life

for those beneficiaries (ii) execute a process to screen each eligible beneficiary for conditions other than those required for inclusion in the demonstration such as impaired cognitive ability and co-morbidities, for the purposes of developing an individualized, goal oriented care management plan (iii) incorporate decision-support tools such as evidence-based practice guidelines or other criteria as determined by the office (iv) incorporate health information and clinical monitoring technologies that enable beneficiary guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment and permit the participant to track and monitor each eligible beneficiaries across settings and to evaluate outcomes (v) designate a nurse case manager as the primary point of contact responsible for communications with the eligible beneficiary and for facilitating communication with other health care providers under the projects (vi) meet any other standard for participation as determined by the office.

(2) To be eligible to submit a request for participation in the chronic care improvement demonstration project, a physician group practice, hospital, or integrated delivery system must employ a delivery practice model that encourages the development of a one-on-one relationship between patients and their practice-based nurse case managers, supplemented by support received from dedicated mental health, pharmacist, and end-of-life components mental health, pharmacy, community resource, end-of-life and financial service components, data analytics care team members. Each nurse case manager shall be located in a physician practice case managers, conduct comprehensive assessments to evaluate the unique needs of each patient, collaborate with physicians and the practice's clinical team to develop treatment plans, facilitate the coordination of patient care across the continuum of health care services, educate patients about options for medical treatment and support services, facilitate patient access to services, support

patient self-management of medical conditions, conduct visits to patient homes on an as-needed basis, and perform other functions deemed necessary to achieve successful health outcomes under the program. The panel of beneficiaries assigned to a nurse case manager shall not exceed 200.

(e) The office shall conduct an annual project evaluation including documentation of (i) cost savings achieved through implementation (ii) improved clinical and quality outcomes, including reductions of preventable hospitalizations, emergency department visits, and by reducing mortality rates, and (iii) beneficiary and provider satisfaction. The office shall submit a report of the evaluation to the senate and house chairs of the joint committee on health care financing and the chairs of the senate and house committees on ways and means.

(f) The office shall, in consult with the Massachusetts General Physicians Organization Care Management Program at Massachusetts General Hospital, promulgate regulations for the phase-in and implementation and evaluation of this demonstration project.

HOUSE DOCKET, NO. 3455 FILED ON: 1/21/2011

HOUSE . . . . . No. 2784

The Commonwealth of Massachusetts

PRESENTED BY:

Harriett L. Stanley

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act to begin to contain health care costs.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Harriett L. Stanley	*2nd Essex*

HOUSE . . . . . No. 2784

By Ms. Stanley of West Newbury, a petition (accompanied by bill, House, No. 2784) of Harriett L. Stanley relative to the determination of need process. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act to begin to contain health care costs.

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

SECTION 1. Chapter 305 of the Acts of 2008 is hereby amended by deleting Section 7 and replacing it with the following new language:

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

which was exempt from determination of need, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; provided further, that expenditures and acquisitions concerned solely with outpatient services other than ambulatory surgery, not otherwise defined as new technology or innovative services by the department, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum, unless the expenditures and acquisitions are at least $7,500,000, in which case a determination of need shall be required. Notwithstanding the above limitations, acute care hospitals only may elect at their option to apply for determination of need for expenditures and acquisitions less than the expenditure minimum.

Chapter 305 of the Acts of 2008 is hereby further amended by in Section 11 deleting the last paragraph and replacing it with the following new language:

Section 53G. Any entity that is certified or seeking certification as an ambulatory surgical center by the Centers for Medicare and Medicaid Services for participation in the Medicare program shall be a clinic for the purpose of licensure under section 51, and shall be deemed to be in compliance with the conditions for licensure as a clinic under said section 51 if it is accredited to provide ambulatory surgery services by the Accreditation Association for Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities or any other national accrediting body that the department determines provides reasonable assurances that such conditions are met. No original license shall be issued pursuant to said section 51 to establish any such ambulatory surgical clinic unless there is a determination by the department that there is a need for such a facility. For purposes of this section, “clinic” shall include a clinic conducted by a

hospital licensed under said section 51 or by the federal government or the commonwealth. The department shall promulgate regulations to implement this section.

SECTION 2. Section 25C of Chapter 111 of the General Laws is amended by inserting after the first paragraph the following new paragraph:

"The Department shall conduct a statewide planning initiative for the purposes of studying and coordinating the availability and delivery of health care services within the commonwealth. The initiative shall examine the current supply of inpatient and outpatient services, and technologies and develop a plan for the provision of new services, beds, technologies, and structural expansions throughout the commonwealth, and develop a plan for the continued role of community hospitals and health centers within the commonwealth. The Department shall utilize this plan in its evaluation of all applications for a determination of need, as required by this section, in order to determine whether the proposed expansion construction, or acquisition of health care facilities or services is needed in the Commonwealth, or whether the proposed expansion construction, or acquisition of health care facilities or services will unnecessary duplicate ongoing services and increase health care costs in the Commonwealth."

SECTION 3. Section 25C of Chapter 111 of the General Laws is amended by inserting at the end of the section the following new paragraph:

"Any hospital seeking to expand its emergency department shall file a determination of need with the department. In addition to the information required pursuant to this section, the department shall require hospitals seeking emergency department expansions to demonstrate that prior to filing a determination of need application, the hospital has implemented measures to

reduce emergency room overcrowding. The department shall promulgate regulations defining the measures hospitals may take to reduce emergency room overcrowding."

Section 25C of Chapter 111 of the General Laws is further amended by inserting at the end of the 2nd paragraph the following language:

"Each person or agency of the commonwealth or any political subdivision thereof filing a determination of need to acquire new technology shall, in addition to the information required by this section, file with the department documentation of programs implemented by the health care facility designed to ensure utilization of all new technology in a manner that is consistent with state and national guidelines. The department shall annually publish a list of state and national guidelines governing the utilization of new technology. The department shall promulgate regulations necessary to enforce this section."

Section 25C of Chapter 111 of the General Laws is further amended by deleting the last sentence of the 7th paragraph and replacing it with the following new language:

"A reasonable fee, established by the department, shall be paid upon the filing of such application. The department shall be adjusted annually as necessary to accommodate the volume of new applications."

Section 3 of Chapter 17 of the General Laws is hereby amended by deleting Section 3 in its entirety and replacing it with the following new language:

Section 3. (a) There shall be a public health council to advise the commissioner of public health and to perform other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 17 members appointed for terms of 6 years under this section.

The commissioner may designate 1 of the members as vice chairperson and may appoint subcommittees or special committees as needed.

(b) Four of the members shall be appointed by the governor: 1 shall be appointed from among the chancellor of the University of Massachusetts Medical School and a list of 3 nominated by said chancellor; 1 shall be appointed from among the dean of the University of Massachusetts Amherst School of Public Health or Health Sciences and a list of 3 nominated by said dean; 1 shall be appointed from among the heads of the non-public schools of medicine in the commonwealth or their nominees; and 1 shall be appointed from among the heads of the non-public schools or programs in public health in the commonwealth or their nominees.

(c) Four of the appointed members shall be providers of health services, appointed by the governor: 1 of whom shall have expertise in acute care hospital management; 1 of whom shall have expertise in long term care management; 1 of whom shall have expertise in home or community-based care management, and 1 of whom shall have expertise in the practice of primary care medicine or public health nursing.

(d) Six of the appointed members shall be non-providers: 1 shall be appointed by the secretary of elder affairs; 1 shall be appointed by the secretary of veterans' services; 1 shall be appointed by the governor from a list of 3 nominated by Health Care For All, Inc.; 1 shall be appointed by the governor from a list of 3 nominated by the Coalition for the Prevention of Medical Errors, Inc.; 1

shall be appointed by the governor from a list of 3 nominated by the Massachusetts Public Health Association; and 1 shall be appointed by the governor from a list of 3 nominated by the Massachusetts Community Health Worker Network. Whenever an organization nominates a list of candidates for appointment by the governor under this subsection, the organization may nominate additional candidates if the governor declines to appoint any of those originally nominated.

(e) Three of the appointed members shall be payers of health care, appointed by the governor: 1 shall represent a health plan licensed in the Commonwealth; 1 shall represent small businesses; and one shall represent large businesses.

(f) For purposes of this section, "non-provider" shall mean a person whose background and experience indicate that he is qualified to act on the council in the public interest; who, and whose spouse, parents, siblings or children, have no financial interest in a health care facility; who, and whose spouse has no employment relationship to a health care facility, to a nonprofit service corporation established under chapters 176A to 176E, inclusive, or to a corporation authorized to insure the health of individuals; and who, and whose spouse, is not licensed to practice medicine.

(g) Upon the expiration of the term of office of an appointive member, his successor shall be appointed in the same manner as the original appointment, for a term of 6 years and until the qualification of his successor. The members shall be appointed not later than 60 days after a vacancy. The council shall meet at least once a month, and at such other times as it shall

determine by its rules, or when requested by the commissioner or any 4 members. The appointive members shall receive $100 per day that the council meets, and their reasonably necessary traveling expenses while in the performance of their official duties.

SECTION 4. Chapter 111 is hereby amended by inserting the following new section:

Section 51 ½. Hospital Billing and Licensure.

As used in this section the following terms shall have the following meanings:

"Facility of Primary Licensure" means the single physical structure and location where the majority of the hospital's licensed beds are located.

(a) Every acute-care hospital that provides any services at a location other than its "Facility of Primary Licensure" is prohibited from operating a Secondary Facility pursuant to the original license of the Facility of Primary Licensure and is hereby required to obtain from the Department a new license for that location if the facility constitutes a Secondary Facility. A facility constitutes a Secondary Facility if:

a. The facility is physically located a distance greater than 500 yards, or

b. The facility requires or maintains separate heating, cooling, electric, sewer systems from the Facility of Primary Licensure.

(b) The licensed Secondary Facility shall obtain from the federal Centers for Medicare and Medicaid Services a separate National Provider Identification Number.

(c) Every health care facility, ambulatory surgical center, or outpatient facility shall bill all public and private payors for services using the National Provider Identification Number assigned to the specific facility and physical locations where the services were provided.

(d) No public or private payor shall be required to pay a claim billed by a health care facility, ambulatory surgical center, or outpatient facility not billed in accordance with this section.

(e) Subject to any agreement between the parties, a Secondary facility shall bill a carrier for services at a rate negotiated by the parties separately from the rates for the Facility of Primary Licensure or in the absence of an agreement, 110% of Medicare.

(f) Notwithstanding the provisions of this chapter the Department shall not grant a license to any Secondary Facility unless there is a determination by the department that there is a need for such a facility pursuant to Section 25C. Secondary Facilities in operation as of the effective date of this section shall be exempt from the Department's determination of need requirements.

(g) The Department along with the Office of the Attorney General shall have the authority to enforce the requirements of this section.

SECTION 5. Chapter 111: Section 70G. Reduction of Duplicate Diagnostic Services

Section 70G. Each hospital in the Commonwealth shall file with the department, within thirty (30) days of the start of the hospital fiscal year, a written plan designed to eliminate the duplication of unnecessary diagnostic services performed on a patient by another hospital or diagnostic facility when there is knowledge of a prior test. The plan shall include the following:

1) Current procedures for sending and receiving diagnostic, imaging and other test results from or to another hospital or provider of care;

2) A defined procedure for determining whether any such test results can be appropriately used in the patient's treatment;

3) A plan to improve the hospital's ability to send and receive such test results from or to other providers of care. The Department shall notify the hospital that the plan has been approved or disapproved within thirty (30) days after filing, based on a determination as to whether the plan adequately addresses the issues of patient safety and costs of duplicating diagnostic tests. If such plan has not been acted upon by the department within thirty (30) days, the plan shall be deemed approved. If the department disapproves of such plan, the hospital shall submit a revised plan within thirty (30) days. If the revised plan continues to be disapproved, or if a hospital fails to submit a plan, the commissioner may issue an order that such a plan be submitted immediately. If such an order is issued, health insurance carriers may deny payment for any duplicate services furnished unless the hospital can establish that the duplicate service was medically necessary and appropriate. In the event that a carrier denies payment for duplicate services, the hospital may not bill the insured for those services.

SECTION 6. Section 51 of Chapter 111 of the General Laws is hereby amended by inserting at the end thereof the following:

Each hospital in the Commonwealth that operates an Emergency Room shall annually file with the Department, within thirty (30) days of the start of the hospital fiscal year, a written operating plan designed to eliminate emergency room overcrowding and diversions. The plan shall include the following:

1) A comprehensive assessment of emergency room wait times for the prior fiscal year, including the average wait time and the number of complaints submitted to the hospital regarding

wait times in the emergency room, and a review of steps taken to reduce the wait time. The assessment shall also include the number of hours the emergency room was on diversion status, broken down by day of the week, and the actual number of emergency diversions for the prior fiscal year;

2) A summary of the specific measures that the hospital will take in the current fiscal year to eliminate overcrowding in the emergency room, such as adjusting elective surgery schedules to reduce variability;

3) The anticipated impact the plan will have on staffing ratios and, after the first year, the actual impact the plan has had for the previous year;

4) A defined set of measures by which to assess the plan's success, such as the number of emergency room diversions, the average wait time to receive emergency services, and/or the percentage of patients in a bed within one hour of arriving in the emergency room;

The Department shall notify the hospital that the plan has been approved or disapproved within twenty (20) days after filing, based on a determination as to whether the plan adequately addresses the needs of emergency room patients. If such plan has not been acted upon by the Department within twenty (20) days, the plan shall be deemed approved. If the Department disapproves of such plan, the hospital shall submit a revised plan within twenty (20) days. If the revised plan continues to be disapproved, or if a hospital fails to submit a plan, the commissioner may take any action deemed appropriate.

SECTION 7. Section 12 of Chapter 118E of the General Laws is hereby amended by inserting at the beginning of the section the following new definitions:

“Managed Care Organization”, any entity with which the Commonwealth contracts to provide managed care services to eligible MassHealth enrollees on a capitated basis.

"Network", a grouping of health care providers who contract with a managed care organization to provide services to MassHealth enrollees covered by the managed care organization’s plans, policies, contracts or other arrangements.

“Non-network provider”, a health care provider who has not entered into a contract with a managed care organization to provide services to MassHealth enrollees.

SECTION 8. Section 12 of Chapter 118E of the General Laws is further amended by inserting at the end of the section the following new language:

For emergency, post-stabilization, and certain other services that have received a prior approval by a managed care organization contracting with the Commonwealth to provide managed care services to MassHealth enrollees, health care providers not included in a managed care organization’s network, must accept a rate equal to the rate paid by Medicaid for the same or similar services. Nothing in this section shall prohibit a managed care organization from denying payment for unapproved services conducted by a non-network provider.

SECTION 9. Chapter 118H of the General Laws is hereby amended by the addition of a new Section 7, as follows:

Section 7. For emergency, post-stabilization, and certain other services that have received a prior approval by a carrier or managed care organization contracting with the Connector to provide managed care services to Commonwealth Care Health Insurance Program enrollees, health care providers not included in a managed care organization’s network, must accept a rate equal to the

rate paid by Medicaid for the same or similar services. Nothing in this section shall prohibit a carrier or managed care organization from denying payment for unapproved services conducted by a non-network provider.

SECTION 10. Chapter 118G is hereby amended by adding the following new Section:

As used in this section, the following words shall have the following meanings:

"Payor", carrier, as defined by M.G.L. Chapter 176O, the group insurance commission established under chapter 32A; and to the extent legally feasible and otherwise not prohibited by any applicable provision of the Employee Retirement Income Security Act of 1974, other employee welfare benefit plans.

Every acute care hospital, health care facility, ambulatory surgical center, or outpatient facility licensed in the commonwealth that does not agree to participate in a payor's network must accept a rate equal 110% of the rate paid by Medicare for the same or similar services. Nothing in this section shall prohibit a payor from denying payment for unapproved services conducted by a non-network provider. Every acute care hospital, health care facility, ambulatory surgical center, or outpatient facility licensed in the commonwealth shall be prohibited from attempting to charge or to collect from the enrollee, or persons acting on the enrollee's behalf, any amount in excess of the amount paid by the payor for that service pursuant to the requirements of this section, other than applicable co-payments, co-insurance and deductibles.

SECTION 11. Chapter 118G of the General Laws is hereby amended by inserting after section 4 the following new section:

4A. Reporting of Hospital Margins

If in any fiscal year, an Acute Hospital, as defined in this chapter, reports to the division an operating margin that exceeds 5 percent, the division shall hold a public hearing within 60 days. The Acute Hospital shall submit testimony on its overall financial condition and the continued need to sustain an operating margin that exceeds 5 percent. The Acute Hospital shall also submit testimony on efforts the Acute Hospital is making to advance health care cost containment and health care quality improvement; and whether, and in what proportion to the total operating margin, the Acute Hospital will dedicate any funds to reducing health care costs. The division shall review such testimony and issue a final report on the results of the hearing. In implementing the requirements of this Section, the Division shall utilize data collected by hospitals pursuant to the requirements of Section 53 of Chapter 288 of the Acts of 2010.

SECTION 12. Chapter 118G of the General Laws is hereby amended by after section 15 inserting the following new section:

15A: Contracting Rights of Private Payors- Unfair Methods of Competition and Unfair or Deceptive Acts or Practices in the Conduct of Health Care Providers

It shall be an unfair business trade practice for any health care provider to attempt to recoup any unreimbursed amounts paid by government payors by increasing charges to other nongovernmental payors. Violations of this section shall be subject to enforcement by the office of the attorney general.

The division shall monitor health care provider charges to ensure compliance with this section and shall report any non-compliance to the attorney general. The division of health care finance and policy in cooperation with the office of the attorney general shall promulgate regulations enforcing this subsection, which shall include penalties for noncompliance.

SECTION 13. Chapter 118G of the General Laws is hereby amended by inserting the following new section:

Section 40 - Review and evaluation of regulatory changes on health insurance

Section 40 (a) For the purposes of this section, a mandated health benefit is a statutory or regulatory requirement that mandates health insurance coverage for specific health services, specific diseases or certain providers of health care services as part of a policy or policies of group life and accidental death and dismemberment insurance covering persons in the service of the commonwealth, and group general or blanket insurance providing hospital, surgical, medical, dental, and other health insurance benefits covering persons in the service of the commonwealth, and their dependents organized under chapter 32A , individual or group health insurance policies offered by an insurer licensed or otherwise authorized to transact accident or health insurance organized under chapter 175 , a nonprofit hospital service corporation organized under chapter 176A , a nonprofit medical service corporation organized under chapter 176B , a health maintenance organization organized under chapter 176G , or an organization entering into a preferred provider arrangement under chapter 176I , any health plan issued, renewed, or delivered within or without the commonwealth to a natural person who is a resident of the commonwealth, including a certificate issued to an eligible natural person which evidences

coverage under a policy or contract issued to a trust or association for said natural person and his dependent, including said person's spouse organized under chapter 176M.

(b) Joint committees of the general court and the house and senate committees on ways and means when reporting favorably on mandated health benefits bills referred to them shall include a review and evaluation conducted by the division of health care finance and policy pursuant to this section.

(c) Upon request of a joint standing committee of the general court having jurisdiction or the committee on ways and means of either branch, the division of health care finance and policy shall conduct a review and evaluation of the mandated health benefit proposal, in consultation with other relevant state agencies, and shall report to the committee within 90 days of the request. If the division of health care finance and policy fails to report to the appropriate committee within 45 days, said committee may report favorably on the mandated health benefit bill without including a review and evaluation from the division.

(d) Any state agency or any board created by statute, including but not limited to the Board of the Commonwealth Connector, the Department of Health, the Division of Medical Assistance or the Division of Insurance that proposes to add a mandated health benefit by rule, bulletin or other guidance must request that a review and evaluation of that proposed mandated health benefit be conducted by the division of health care finance and policy pursuant to this section. The report on the mandated health benefit by the division of health care finance and policy must be received by the agency or board and available to the public at least 30 days prior to any public hearing on the proposal. If the division of health care finance and policy fails to report to the agency or board within 45 days of the request, said agency or board may proceed with a public hearing on

the mandated health benefit proposal without including a review and evaluation from the division.

(e) Any party or organization on whose behalf the mandated health benefit was proposed shall provide the division of health care finance and policy with any cost or utilization data that they have. All interested parties supporting or opposing the proposal shall provide the division of health care finance and policy with any information relevant to the division's review. The division shall enter into interagency agreements as necessary with the division of medical assistance, the group insurance commission, the department of public health, the division of insurance, and other state agencies holding utilization and cost data relevant to the division's review under this section. Such interagency agreements shall ensure that the data shared under the agreements is used solely in connection with the division's review under this section, and that the confidentiality of any personal data is protected. The division of health care finance and policy may also request data from insurers licensed or otherwise authorized to transact accident or health insurance under chapter 175 , nonprofit hospital service corporations organized under chapter 176A , nonprofit medical service corporations organized under chapter 176B , health maintenance organizations organized under chapter 176G , and their industry organizations to complete its analyses. The division of health care finance and policy may contract with an actuary, or economist as necessary to complete its analysis.

The report shall include, at a minimum and to the extent that information is available, the following: (1) the financial impact of mandating the benefit, including the extent to which the proposed insurance coverage would increase or decrease the cost of the treatment or service over the next 5 years, the extent to which the proposed coverage might increase the appropriate or inappropriate use of the treatment or service over the next 5 years, the extent to which the

mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service, the extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next 5 years, the effects of mandating the benefit on the cost of health care, particularly the premium, administrative expenses and indirect costs of municipalities, large employers, small employers, employees and nongroup purchasers, the potential benefits and savings to municipalities, large employers, small employers, employees and nongroup purchasers, the effect of the proposed mandate on cost shifting between private and public payors of health care coverage, the cost to health care consumers of not mandating the benefit in terms of out of pocket costs for treatment or delayed treatment and the effect on the overall cost of the health care delivery system in the commonwealth; (2) the medical efficacy of mandating the benefit, including the impact of the benefit to the quality of patient care and the health status of the population and the results of any research demonstrating the medical efficacy of the treatment or service compared to alternative treatments or services or not providing the treatment or service; and (3) if the proposal seeks to mandate coverage of an additional class of practitioners, the results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered and the methods of the appropriate professional organization that assures clinical proficiency.

SECTION 14. Chapter 118G: Section 19. Reduction of Preventable Hospital Readmissions

As used in this section, the following words shall have the following meanings:

"Potentially Preventable Readmission" (PPR) shall mean a readmission to a hospital that follows a prior discharge from a hospital within 14 days, and that is clinically-related to the prior hospital admission.

"Observed rate of Readmission" shall meant the number of admissions in each hospital that were actually followed by at least one PPR divided by the total number of admissions.

"Expected Rate of Readmission" shall mean a risk adjusted rate for each hospital that accounts for the severity of illness, and age of patients at the time of discharge preceding the readmission.

"Excess Rate of Readmission" shall mean the difference between the observed rates of potentially preventable readmissions and the expected rate of potentially preventable readmissions for each hospital.

(a) Potentially Preventable Readmission criteria.

1) A hospital readmission is a return hospitalization following a prior discharge that meets all of the following criteria:

a. The readmission could reasonably have been prevented by the provision of appropriate care consistent with accepted standards in the prior discharge or during the post discharge follow-up period.

b. The readmission is for a condition or procedure related to the care during the prior hospitalization or the care during the period immediately following the prior discharge and including, but not limited to:

i. The same or closely related condition or procedure as the prior discharge.

ii. An infection or other complication of care.

iii. A condition or procedure indicative of a failed surgical intervention.

iv. An acute decompensation of a coexisting chronic disease.

c. The readmission is back to the same or to any other hospital.

2) Readmissions, for the purposes of determining potentially preventable readmissions, excludes the following circumstances:

a. The original discharge was a patient initiated discharge and was Against Medical Advice (AMA) and the circumstances of such discharge and readmission are documented in the patient's medical record.

b. The original discharge was for the purpose of securing treatment of a major or metastatic malignancy, multiple trauma, burns, neonatal and obstetrical admissions.

c. The readmission was a planned readmission or one that occurred on or after 15 days following an initial admission.

(b) The division shall develop a methodology to calculate the expected rate of potentially preventable readmissions for each hospital, and calculate the excess rate of readmission.

(c) The division shall measure the observed rate of readmission, and on a regular and ongoing basis; publish on its website the rates of potentially preventable hospital readmission rates for each hospital licensed in the commonwealth using the definitions and criteria set for in this section. The division shall calculate and publish, both by individual hospital and statewide, the observed rate of readmission, the expected rate of readmission and the excess rate of readmission

for each hospital. In compiling the data necessary for the calculation, the division shall, to the maximum extent feasible, utilize existing data collected from hospitals and carriers.

(d) The division shall convene an advisory committee to develop a standardized methodology to be applied to payments to hospitals that report excess readmissions and make recommendations for a consistent methodology to be adopted across all payers to reduce hospital payments for those hospitals with excess readmissions. The advisory committee shall consist of the commissioner of the division of health care finance and policy, who shall serve as chair; the commissioner of the group insurance commission, or designee; the director of the office of Medicaid, or designee; the commissioner of the department of public health, or designee; the executive director of the commonwealth connector, or designee; one member representing the Massachusetts association of health plans, one member representing the Massachusetts hospital association, one member representing the Massachusetts medical society, one members with expertise in hospital billing and payment, and one member with expertise in hospital reimbursement.

The advisory committee shall convene no later than January 1, 2012 and shall develop its recommendation by no later than April 1, 2012, which shall include a plan to implement the recommended methodologies in all state programs including the state Medicaid program, the health safety net care pool, and the commonwealth care program.

SECTION 15. Chapter 6A of the General Laws, as appearing in the 2008 official edition, is hereby amended by adding after section 16, the following new section:

16A. The division of health care finance and policy shall be the sole repository for health care data collected pursuant to Section 6 of Chapter 118G. The division shall collect, store and

maintain such data in a payer and provider claims database created under said section 6. All other agencies, authorities, councils, boards, and commissions of the commonwealth seeking health care data that is collected under said section 6 shall utilize such data prior to requesting any data from health care providers and payers. The division may enter into interagency services agreements for transfer and use of the data.

SECTION 16. Section 6 of chapter 118G of the General Laws as amended by chapters 131 and 288 of the acts of 2010 is hereby amended by adding at the beginning thereof the following:

"(a). The division shall establish an all payer and provider health care claims database to record and maintain all information collected by the division under subsection (b). The division shall be the sole administrator and operator of said database and shall be responsible for safeguarding the privacy of information collected, recorded and maintained.

There shall be established a reviewing committee to advise the commissioner on the administration of the data base. The reviewing committee shall be comprised of representatives from the hospital, health plan and provider communities, and shall include, but not be limited to the following: a representative of the Massachusetts Hospital Association, a representative of Blue Cross and Blue Shield of Massachusetts, a representative of the Massachusetts Association of Health Plans, and a representative of the Massachusetts Medical Society. The reviewing committee shall be responsible for advising the division on the standards for release and use of the information submitted and shall ensure that such standards protect patient privacy and guard against utilization of the data for the purpose of anti-competitive behavior.

SECTION 17. Said section 6 is hereby further amended by adding at the end thereof the following:

(c) The division shall provide access to information recorded and maintained in the database only in accordance with the division's requirements for protecting patient privacy and shall guard against utilization of the data for the purpose of anti-competitive behavior. Health care providers and payers that supply the data under this section may only be charged reasonable administrative fees for access to information in the database

SECTION 18. Chapter 176O of the General Laws, as appearing in the 2006 Official Edition, is hereby amended by inserting after section 20, the following new section:

Section 21. Beginning January 1, 2010, all hospitals, physician practices and carriers shall conduct the following transactions electronically:

1. Eligibility for a health plan transaction, as described under Code of Federal Regulations, title 45, part 162, subpart L;

2. Health care payment and remittance advice transaction, as described under Code of Federal Regulations, title 45, part 162, subpart P;

3. Health care claims or equivalent encounter information transaction, as described under Code of Federal Regulations, title 45, part 162, subpart K;

SECTION 19. Section 108 of Chapter 175 of the General Laws, as appearing in the Official Edition, is hereby amended by striking out subsection 4(c) and inserting in place thereof the following:

4(c). Within fifteen days after an insurer's receipt of notice of claim by a claimant or provider under a policy of accident and sickness insurance which is delivered or issued for delivery in the commonwealth, and which provides hospital expense, medical expense, surgical expense or

dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud. Beginning on January 1, 2006, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 20. Section 110 of Chapter 175 of the General Laws, as appearing in the Official Edition, is hereby amended by striking out subsection (G) and inserting in place thereof the following:

(G) For purposes of this section the term ""notice of a claim" shall mean any notification whether in writing or otherwise, to an insurer or its authorized agent, by any person, firm, association, or corporation asserting right to payment under a policy of insurance which reasonably apprises the insurer of the existence of a claim.

Within fifteen days after an insurer's receipt of notice of claim by a claimant under a general or blanket policy of accident and sickness insurance which is delivered or issued for delivery in the commonwealth, and which provides hospital expense, medical expense, surgical expense or dental expense insurance, the insurer shall furnish such forms as are usually furnished by it for

filing proofs of loss. Within forty-five days from said receipt of notice if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 21. Chapter 176G of the General Laws, as appearing in the Official Edition, is hereby amended by striking out section 6 and inserting in place thereof the following:

Section 6. A health maintenance organization may enter into contractual arrangements with any other person or company for the provision, to the health maintenance organization, of health services, insurance, reinsurance and administrative, marketing, underwriting or other services on a nondiscriminatory basis. A health maintenance organization shall not refuse to contract with or compensate for covered services an otherwise eligible provider solely because such provider has in good faith communicated with one or more of his current, former or prospective patients regarding the provisions, terms or requirements of the organization's products as they relate to the needs of such provider's patients. No contract between a participating provider of health care services and a health maintenance organization shall be issued or delivered in the commonwealth unless it contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the provider of health care services, the health

maintenance organization shall (i) make payments for such services provided, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the health maintenance organization fails to comply with this paragraph for any claims related to the provision of health care services, said health maintenance organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the health maintenance organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the health maintenance organization is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 22. Chapter 176I of the General Laws, as appearing in the Official Edition, is hereby amended by striking section 2 and inserting in place thereof the following:

Section 2. An organization may enter into a preferred provider arrangement with one or more health care providers upon a determination by the commissioner that the organization and the arrangement comply with the requirements of this chapter and the regulations hereunder. An organization shall not condition its willingness to allow any health care provider to participate in a preferred provider arrangement on such health care provider's agreeing to enter into other contracts or arrangements with the organization that are not part of or related to such preferred provider arrangements. An organization shall not refuse to contract with or compensate for covered services an otherwise eligible participating or nonparticipating provider solely because such provider has in good faith communicated with one or more of his current, former or

prospective patients regarding the provisions, terms or requirements of the organization's products as they relate to the needs of such provider's patients. An organization shall submit information concerning any proposed preferred provider arrangements to the commissioner for approval in accordance with regulations promulgated by the commissioner. Said regulations shall comply with the applicable provisions of chapter thirty A of the General Laws. Said information shall include at least the following: (a) a description of the health services and any other benefits to which the covered person is entitled; (b) a description of the locations where and the manner in which health services and other benefits may be obtained; (c) a copy of the evidence of coverage; (d) copies of any contracts with preferred providers; (e) a description of the rating methodology and rates. The arrangement shall meet the following standards: (a) Standards for maintaining quality health care, including satisfying any quality assurance regulations promulgated by any state agency; (b) Standards for controlling health care costs; (c) Standards for assuring reasonable levels of access of health care services and an adequate number and geographical distribution of preferred providers to render those services; (d) Standards for assuring appropriate utilization of health care service; and (e) Other standards deemed appropriate by the commissioner.

No organization may enter into a preferred provider arrangement with one or more health care providers unless said written arrangement contains a provision requiring that within 45 days after the receipt by the organization of completed forms for reimbursement to the health care provider, the organization shall (i) make payments for the provision of such services, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the organization fails to comply with the provisions of this paragraph for any

claims related to the provision of health care services, said organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the organization is investigating because of suspected fraud. Beginning on January 1, 2008, the provisions of this paragraph shall only apply to claims for reimbursement submitted electronically.

SECTION 23. Section one of Chapter 175 of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new definitions:—

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

“State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

"Policy of Accident and Sickness Insurance," any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of this chapter.

SECTION 24. Section 108 of chapter 175 of the General Laws, as so appearing, is hereby further amended by adding the following new paragraph at the end thereof:—

A carrier authorized to transact individual policies of accident or sickness insurance under this section may offer a flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the carrier shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

SECTION 25. Section 110 of chapter 175, as so appearing, is hereby amended by inserting the following new paragraph at the end thereof:—

A carrier authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the carrier shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The carrier shall provide each

subscriber under a group policy upon enrollment with written notice stating that this is a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 26. Chapter 176A of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new section:—

Section 1D. Definitions

The following words, as used in this chapter, unless the text otherwise requires or a different meaning is specifically required, shall mean-

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

"Policy of Accident and Sickness Insurance," any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

SECTION 27. Section 8 of chapter 176A of the General Laws, as so appearing, is hereby further amended by adding the following paragraphs at the end thereof:—

(h) A non-profit hospital service corporation authorized to transact individual policies of accident or sickness insurance under this section may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the non-profit hospital service corporation shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

(i) A non-profit hospital service corporation authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the non-profit hospital service corporation shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The non-profit hospital service corporation shall provide each subscriber under a group policy upon enrollment with written notice stating that this is a flexible

health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 28. Section one of Chapter 176B of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new definitions:—

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

SECTION 29. Section 4 of chapter 176B of the General Laws, as so appearing, is hereby further amended by adding the following paragraphs at the end thereof:—

A medical service corporation authorized to transact individual policies of accident or sickness insurance under this chapter may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the medical service corporation shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

A medical service corporation authorized to transact group policies of accident or sickness insurance under this section may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the medical service corporation shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits.

The medical service corporation shall provide each subscriber under a group policy upon enrollment with written notice stating that this is a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 30. Section one of Chapter 176G of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting the following new definitions:—

“Flexible health benefit policy” means a health insurance policy that in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits" means coverage required or required to be offered in the general or special laws as part of a policy of accident or sickness insurance that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

“Policy of Accident and Sickness Insurance,” any policy or contract covering the kind or kinds of insurance described in subdivisions (a) through (d) of the sixth paragraph of section 47 of chapter 175 of the general laws.

SECTION 31. Section 4 of chapter 176G of the General Laws, as so appearing, is hereby further amended by adding the following paragraph at the end thereof:—

A health maintenance organization authorized to transact individual policies of accident or sickness insurance under this chapter may offer a one flexible health benefit policy, provided however, that for each sale of a flexible health benefit policy the health maintenance organization shall provide to the prospective policyholder written notice describing the state mandated health benefits that are not included in the policy and provide to the prospective

individual policyholder the option of purchasing at least one health insurance policy that provides all state mandated health benefits.

SECTION 32. Chapter 176G, as so appearing, is hereby further amended by inserting the following new section:

Section 4A. A health maintenance organization authorized to transact group policies of accident or sickness insurance under this chapter may offer one or more flexible health benefit policies; provided however, that for each sale of a flexible health benefit policy the health maintenance organization shall provide to the prospective group policyholder written notice describing the state mandated benefits that are not included in the policy and provide to the prospective group policyholder the option of purchasing at least on health insurance policy that provides all state mandated benefits. The health maintenance organization shall provide each subscriber under a group policy upon enrollment with written notice stating that this is a flexible health benefit policy and describing the state mandated health benefits that are not included in the policy.

SECTION 33. Chapter 176M of the General Laws, as appearing in the 2002 Official Edition, is hereby amended by inserting in section one the following new definitions:—

"Flexible health benefit policy" means a health insurance that, in whole or in part, does not offer state mandated health benefits.

"State mandated health benefits" means coverage required to be offered any general or special law that:

1. includes coverage for specific health care services or benefits;

2. places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or

3. includes a specific category of licensed health care practitioner from whom an insured is entitled to receive care.

SECTION 34. Section 2 of said chapter 176M is hereby amended by striking out the first sentence of paragraph (d) and inserting in place thereof the following:

A carrier that participates in the nongroup health insurance market shall make available to eligible individuals a standard guaranteed health plan established pursuant to paragraph (c) and may additionally make available to eligible individuals no more than two alternative guaranteed issue health plans, one of which may be a flexible health benefit policy, with benefits and cost sharing requirements, including deductibles, that differ from the standard guaranteed issue health plan.

SECTION 35. Chapter 175 of the General Laws 175 is hereby amended by inserting after section 111H, the following section:--

Section 111I. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a policy of accident and sickness insurance which provides hospital expense and

surgical expense insurance solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A)diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a policy of accident and sickness insurance which provides hospital expense and surgical expense insurance that does not include coverage for at least one mandated benefit unless the carrier continues to offer at least one policy that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a policy of accident and sickness insurance to any employee within 12 months.

SECTION 36. Chapter 176A of the General Laws is hereby amended by inserting after section 1D the following section:

Section 1E. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a contract between a subscriber and the corporation under an individual or group hospital services plan solely on the basis that it does not include coverage for at least one mandated benefit.

(b) The commissioner shall not approve a contract unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A)diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a contract that does not include coverage for at least one mandated benefit unless the corporation continues to offer at least one contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a hospital services plan, to any employee within 12 months.

SECTION 37. Chapter 176B of the General Laws is hereby further amended by inserting after section 6B, the following section:-- Section 6C. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a subscription certificate solely on the basis that it does not include coverage for at least one mandated benefit.

(b) The commissioner shall not approve a subscription certificate unless it provides, at a minimum, coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A)diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a subscription certificate that does not include coverage for at least 1 mandated benefit unless the corporation continues to offer at least one subscription certificate that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out this section. (f) Notwithstanding any special or general law to the contrary, no plan approved by the

commissioner under this section shall be available to an employer who has provided a subscription certificate, to any employee within 12 months.

SECTION 38. Chapter 176G of the General Laws is hereby amended by inserting after Section 16 the following new section:

Section 16A. (a) Except as otherwise provided in this section, the commissioner shall not disapprove a health maintenance contract solely on the basis that it does not include coverage for at least 1 mandated benefit.

(b) The commissioner shall not approve a health maintenance contract unless it provides coverage for:

(1) pregnant women, infants and children as set forth in section 47C;

(2) prenatal care, childbirth and postpartum care as set forth in section 47F;

(3) cytologic screening and mammographic examination as set forth in section 47G;

(3A)diabetes-related services, medications, and supplies as defined in section 47N;

(4) early intervention services as set forth in said section 47C; and

(5) mental health services as set forth in section 47B; provided however, that if the policy limits coverage for outpatient physician office visits, the commissioner shall not disapprove the policy on the basis that coverage for outpatient mental health services is not as extensive as required by said section 47B, if the coverage is at least as extensive as coverage under the policy for outpatient physician services.

(c) The commissioner shall not approve a health maintenance contract that does not include coverage for at least one mandated benefit unless the health maintenance organization continues to offer at least one health maintenance contract that provides coverage that includes all mandated benefits.

(d) For purposes of this section, "mandated benefit" shall mean a requirement in this chapter that requires coverage for specific health services, specific diseases or certain providers of health care.

(e) The commissioner may promulgate rules and regulations as are necessary to carry out the provisions of this section.

(f) Notwithstanding any special or general law to the contrary, no plan approved by the commissioner under this section shall be available to an employer who has provided a health maintenance contract, to any employee within 12 months.

SECTION 39. It shall be the policy of the general court to impose a moratorium on all new mandated health benefit legislation until the later of July 31, 2012, or until the rate of increase in the Consumer Price Index (CPI) for medical care services as reported by the United States Bureau of Labor Statistics remains at zero or below zero for two consecutive years.

SECTION 40. Chapter 118E of the General Laws is hereby amended by adding the following new section:

Section 62 - The Executive Office of Health and Human Services shall discontinue membership in the MassHealth fee-for-service program and primary care clinician plan, and shall begin to enroll all members meeting eligibility requirements, as established pursuant to applicable federal

and state law and regulation, into a Medicaid managed care organization that has contracted with the commonwealth to deliver such managed care services, in accordance with the enrollment and assignment process for other eligible categories and at the appropriate levels of premium.

SECTION 41.

Section 40 of this act shall take effect on January 1, 2012.

HOUSE DOCKET, NO. 3230 FILED ON: 1/21/2011

HOUSE . . . . . No. 2785

The Commonwealth of Massachusetts

PRESENTED BY:

Daniel K. Webster

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to managed care services .

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Daniel K. Webster	*6th Plymouth*
Donald F. Humason, Jr.	*4th Hampden*
Steven L. Levy	*4th Middlesex*
Bradley H. Jones, Jr.	*20th Middlesex*

HOUSE . . . . . No. 2785

By Mr. Webster of Pembroke, a petition (accompanied by bill, House, No. 2785) of Daniel K. Webster and others relative to managed care services. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to managed care services .

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

"SECTION 1. Chapter 118E of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding the following new section:- Section 63. The executive office of health and human services shall discontinue membership in the MassHealth fee-for-service program and primary care clinician plan, and shall begin enrolling all members meeting eligibility requirements as established pursuant to applicable federal and state law and regulation, and for whom the discontinuation would result in cost savings for the MassHealth program, into a Medicaid managed care organization that has contracted with the commonwealth to deliver such managed care services, in accordance with the enrollment and assignment processes for other eligible categories and at the appropriate levels of premium. The office shall submit a report to the joint committee on health care financing and the clerks of the house and the senate by June 30, 2012 detailing which members it has newly enrolled in a Medicaid managed care organization, which members it has maintained in the MassHealth fee-for-service program and primary care clinician plan, and an actuarial justification for those members who have not been transferred to a Medicaid managed care organization.".

HOUSE DOCKET, NO. 680 FILED ON: 1/18/2011

HOUSE . . . . . No. 3354

The Commonwealth of Massachusetts

PRESENTED BY:

Ronald Mariano

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to public reporting of hospital margins.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Ronald Mariano	*3rd Norfolk*

HOUSE . . . . . No. 3354

By Mr. Mariano of Quincy, a petition (accompanied by bill, House, No. 3354) of Ronald Mariano relative to public reporting of hospital financial margins. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to public reporting of hospital margins.

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

SECTION 1. Chapter 118G of the General Laws is hereby amended by inserting after section 4 the following new section: 4A. Reporting of Hospital Margins If in any fiscal year, an Acute Hospital, as defined in this chapter, reports to the division an operating margin that exceeds 5 percent, the division shall hold a public hearing within 60 days. The Acute Hospital shall submit testimony on its overall financial condition and the continued need to sustain an operating margin that exceeds 5 percent. The Acute Hospital shall also submit testimony on efforts the Acute Hospital is making to advance health care cost containment and health care quality improvement; and whether, and in what proportion to the total operating margin, the Acute Hospital will dedicate any funds to reducing health care costs. The division shall review such testimony and issue a final report on the results of the hearing. In implementing the requirements of this Section, the Division shall utilize data collected by hospitals pursuant to the requirements of Section 53 of Chapter 288 of the Acts of 2010.

HOUSE . . . . . No. 3614

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

An Act encouraging nurse practitioner and physician assistant practice of primary care..

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

SECTION 1. Section 2 of chapter 32A of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by striking out paragraph (i) and inserting in place thereof the following two paragraphs:

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

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

SECTION 2. Section 22 of said chapter 32A, as so appearing, is hereby amended by striking out, in line 48, the word "physician" and inserting in place thereof the following word:- provider.

SECTION 3. Section 2 of chapter 32B of the General Laws, as so appearing, is hereby amended by adding the following paragraph:-

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

SECTION 4. Section 19 of said chapter 32B, as so appearing, is hereby amended by striking out, in line 127, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 5. Section 1 of chapter 111 of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Nuclear reactor” the following definition:-

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

SECTION 6. Section 4J of said chapter 111, as so appearing, is hereby amended by striking out, in line 15, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 7. Section 25L of said chapter 111, as so appearing, is hereby amended by inserting after the word “providers”, in line 9, the following words:- physician assistants practicing as primary care providers.

SECTION 8. Clause (ii) of subsection (a) of section 25L of said chapter 111, as so appearing, is hereby amended by striking out subclause (5) and inserting in place thereof the following subclause:-

(5) studying the capacity of public and private medical, nursing, and physician assistant schools in the commonwealth to expand the supply of primary care physicians, nurse practitioners practicing as primary care providers, and physician assistants practicing as primary care providers.

SECTION 9. Section 25L of said chapter 111, as so appearing, is hereby amended by striking out subsection (d) and inserting in place thereof the following subsection:-

(d) The center shall annually submit a report, not later than March 1, to the governor; the health care quality and cost council established by section 16K of chapter 6A, the health disparities council established by section 16O of chapter 6A; and the general court, by filing the report with the clerk of the house of representatives, the clerk of the senate, the joint committee on labor and workforce development, the joint committee on health care financing, and the joint committee on public health. The report shall include: (i) data on patient access and regional disparities in access to physicians, by specialty and sub-specialty, nurses, and physician assistants; (ii) data on factors influencing recruitment and retention of physicians, nurses, and physician assistants; (iii) short and long-term projections of physician, nurse, and physician assistant supply and demand; (iv) strategies being employed by the council or other entities to address workforce needs, shortages, recruitment and retention; (v) recommendations for designing, implementing and improving programs or policies to address workforce needs, shortages, recruitment and retention;

and (vi) proposals for statutory or regulatory changes to address workforce needs, shortages, recruitment and retention.

SECTION 10. Chapter 111 of the General Laws is hereby amended by striking out section 25MN, as so appearing, and inserting in place thereof the following section:-

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

(b) The council shall consist of 18 members who shall be appointed by the governor: 1 of whom shall be a representative of the Massachusetts Extended Care Federation; 1 of whom shall be a physician with a primary care specialty designation who practices in a rural area; 1 of whom shall be a physician with a primary care specialty who practices in an urban area; 1 of whom shall be a physician with a medical subspecialty; 1 of whom shall be an advanced practice nurse, authorized under section 80B of said chapter 112, who practices in a rural area; 1 of whom shall be an advanced practice nurse, authorized under said section 80B of said chapter 112, who practices in an urban area; 1 of whom shall be a physician assistant with a primary care specialty, authorized under section 9E of said chapter 112, 1 of whom shall be a representative of the Massachusetts Organization of Nurse Executives; 1 of whom shall be a representative of the Massachusetts Academy of Family Physicians; 1 of whom shall be a representative of the Massachusetts Workforce Board Association; 1 of whom shall be a representative of the Massachusetts League of Community Health Centers, Inc.; 1 of whom shall be a representative of the Massachusetts Medical Society; 1 of whom shall be a representative of the Massachusetts

Center for Nursing, Inc.; 1 of whom shall be a representative of the Massachusetts Nurses Association; 1 of whom shall be a representative of the Massachusetts Association of Registered Nurses; 1 of whom shall be a representative of the Massachusetts Association of Physician Assistants; 1 of whom shall be a representative of the Massachusetts Hospital Association, Inc.; and 1 of whom shall be a representative of Health Care For All, Inc. Members of the council shall be appointed for terms of 3 years or until a successor is appointed. Members shall be eligible to be reappointed and shall serve without compensation, but may be reimbursed for actual and necessary expenses reasonably incurred in the performance of their duties. Vacancies of unexpired terms shall be filled within 60 days by the appropriate appointing authority.

The members of the council shall annually elect a chair, vice chair and secretary and may adopt by-laws governing the affairs of the council.

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

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

SECTION 11. Paragraph (a) of section 25N of said chapter 111, as so appearing, is hereby amended by striking out clause (i) and inserting in place thereof the following clause:-

(i) are graduates of medical, nursing, or physician assistant schools;

SECTION 12. Paragraph (d) of said section 25N of said chapter 111, as so appearing, is hereby amended by striking out clause (i) and inserting in place thereof the following clause:-

(i) the number of applicants, the number accepted, and the number of participants by race; gender; medical, nursing, or physician assistant specialty; medical, nursing, or physician assistant school; residence prior to medical, nursing, or physician assistant school; and where they plan to practice after program completion;

SECTION 13. Section 67F of said chapter 111, as so appearing, is hereby amended by striking out, in line 15, the word "physician" and inserting in place thereof the following word:- provider.

SECTION 14. Section 67F of said chapter 111, as so appearing, is hereby further amended by striking out, in line 19, the word "physician" and inserting in place thereof the following word:- provider.

SECTION 15. Section 9E of chapter 112 of the General Laws, as so appearing, is hereby amended by striking out the third sentence.

SECTION 16. Said chapter 112, as so appearing, is hereby amended by inserting after section 80H the following section:-

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

guidelines between the nurse practitioner and supervising physician under section 80E of chapter 112.

SECTION 17. Section 8 of chapter 118E of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after paragraph (f). the following paragraph:-

(f1/2). “Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.

SECTION 18. Section 17A of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 60 and 62, the word “physician” and inserting in place thereof the following word in each instance:- provider.

SECTION 19. The third paragraph of section 6 of chapter 118G of the General Laws, as so appearing, is hereby amended by striking out clauses (ii) and (iii) and inserting in place thereof the following three clauses:-

(ii) changes in the benefit and cost-sharing design of plans offered by these payers; (iii) changes in measures of plan cost and utilization; provided that this analysis shall facilitate comparison among plans and between public and private payers; and (iv) the type of provider who delivered care.

SECTION 20. The fifth paragraph of section 6 of Chapter 118G of the General Laws, as amended by section 13 of chapter 288 of the acts of 2010, is hereby further amended by striking out clauses (viii) and (ix), and inserting in place thereof the following three clauses:-

(viii) relative prices paid to every hospital, physician group, ambulatory surgical center, freestanding imaging center, mental health facility, rehabilitation facility, skilled nursing facility and home health provider in the payer's network, by type of provider and calculated according to a uniform methodology; (ix) hospital inpatient and outpatient costs, including direct and indirect costs, according to a uniform methodology; and (x) information concerning the type of provider who delivered care.

SECTION 21. Section 1 of chapter 175 of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after the definition of “Net value of policies” the following definition:-

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

SECTION 22. Section 47B of said chapter 175, as so appearing, is hereby amended by striking out, in line 64, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 23. Section 47U of said chapter 175, as so appearing, is hereby amended by striking out, in lines 62 and 64, the word “physician” and inserting in place thereof the following word in each instance:- provider.

SECTION 24. Section 8A of chapter 176A of the General Laws, as so appearing, is hereby amended by striking out, in line 58, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 25. Subsection (c) of said section 8A of chapter 176A, as so appearing, is hereby amended by adding the following paragraph:-

For the purposes of this subsection, the term “primary care provider” shall mean a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.

SECTION 26. Section 8U of said chapter 176A, as so appearing, is hereby amended by striking out, in lines 64 and 66, the word “physician” and inserting in place thereof the following word in each instance:- provider.

SECTION 27. Subsection (c) of said section 8U of chapter 176A, as so appearing, is hereby amended by adding the following paragraph:-

For the purposes of this subsection, the term “primary care provider” shall mean a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.

SECTION 28. Section 1 of chapter 176B of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Participating optometrist” the following definition:-

“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise

provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.

SECTION 29. Section 4A of said chapter 176B, as so appearing, is hereby amended by striking out, in line 60, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 30. Section 4U of said chapter 176B, as so appearing, is hereby amended by striking out, in lines 64 and 66, the word “physician” and inserting in place thereof the following word in each instance:- provider.

SECTION 31. Section 1 of chapter 176G of the General Laws, as so appearing, is hereby amended by inserting after the definition of “Person” the following definition:-

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

SECTION 32. Section 4M of said chapter 176G, as so appearing, is hereby amended by striking out, in line 54, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 33. Section 5 of said chapter 176G, as so appearing, is hereby amended by striking out, in lines 59 and 61, the word “physician” and inserting in place thereof the following word in each instance:- provider.

SECTION 34. Section 11 of chapter 176J of the General Laws, as appearing in section 73 of chapter 288 of the acts of 2010, is hereby amended by striking out subsection (b) and inserting in place thereof the following subsection:-

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

The commissioner shall promulgate regulations requiring the uniform reporting of tiering information, including, but not limited to requiring, at least 90 days before the proposed effective date of any tiered network plan or any modification in the tiering methodology for any existing tiered network plan, the reporting of a detailed description of the methodology used for tiering providers, including: the statistical basis for tiering; a list of providers to be tiered at each member cost-sharing level; a description of how the methodology and resulting tiers will be communicated to each network provider, eligible individuals and small groups; and a description of the appeals process a provider may pursue to challenge the assigned tier level.

SECTION 35. Section 1 of chapter 176O of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after the definition of “Person” the following definition:-

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

SECTION 36. Section 7 of said chapter 176O, as so appearing, is hereby amended by striking out, in line 30, the word “physician” and inserting in place thereof the following word:- provider.

SECTION 37. Chapter 176O of the General Laws is hereby amended by striking out section 15, as so appearing, and inserting in place thereof the following section:-

Section 15. (a) A carrier that allows or requires the designation of a primary care provider shall notify an insured at least 30 days before the disenrollment of such insured's primary care provider and shall permit such insured to continue to be covered for health services, consistent with the terms of the evidence of coverage, by such primary care provider for at least 30 days after said physician provider is disenrolled, other than disenrollment for quality-related reasons or for fraud. Such notice shall also include a description of the procedure for choosing an alternative primary care provider.

(b) A carrier shall allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, for the period up to and including the insured's first postpartum visit.

(c) A carrier shall allow any insured who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said provider, consistent with the terms of the evidence of coverage, until the insured's death.

(d) A carrier shall provide coverage for health services for up to 30 days from the effective date of coverage to a new insured by a provider who is not a participating provider in the carrier's

network if: (1) the insured's employer only offers the insured a choice of carriers in which said provider is not a participating provider, and (2) said provider is providing the insured with an ongoing course of treatment or is the insured's primary care provider. With respect to a insured in her second or third trimester of pregnancy, this provision shall apply to services rendered through the first postpartum visit. With respect to an insured with a terminal illness, this provision shall apply to services rendered until death.

(e) A carrier may condition coverage of continued treatment by a provider under subsections (a) to (d), inclusive, upon the provider's agreeing (1) to accept reimbursement from the carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (2) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and (3) to adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the carrier. Nothing in this subsection shall be construed to require the coverage of benefits that would not have been covered if the provider involved remained a participating provider.

(f) A carrier that requires an insured to designate a primary care provider shall allow such a primary care provider to authorize a standing referral for specialty health care provided by a health care provider participating in such carrier's network when (1) the primary care provider determines that such referrals are appropriate, (2) the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care provider with all necessary clinical and administrative information on a regular basis, and (3) the health care services to be provided

are consistent with the terms of the evidence of coverage. Nothing in this section shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(g) No carrier shall require an insured to obtain a referral or prior authorization from a primary care provider for the following specialty care provided by an obstetrician, gynecologist, certified nurse-midwife or family practitioner participating in such carrier's health care provider network: (1) annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse-midwife or family practitioner to be medically necessary as a result of such examination; (2) maternity care; and (3) medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions. No carrier shall require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care provider. Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse-midwives or family practitioners to communicate with an insured's primary care provider regarding the insured's condition, treatment, and need for follow-up care. Nothing in this section shall be construed to permit an obstetrician, gynecologist, certified nurse-midwife or family practitioner to authorize any further referral of an insured to any other provider without the approval of the insured's carrier.

(h) A carrier shall provide coverage of pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such services.

(i) A carrier, including a dental or vision carrier, shall provide health, dental or vision care providers applying to be participating providers who are denied such status with a written reason or reasons for denial of such application.

(j) No carrier shall make a contract with a health care provider which includes a provision permitting termination without cause. A carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment.

(k) A carrier, including a dental or vision carrier, shall provide insureds, upon request, interpreter and translation services related to administrative procedures.

SECTION 38. Section 20 of said chapter 176O, as so appearing, is hereby amended by striking out, in lines 19 and 22, the words “care physician” and inserting in place thereof the following word:- care provider.

SECTION 39. The General Laws are hereby amended by inserting after chapter 176R the following chapter:-

Chapter 176S

CONSUMER CHOICE OF PHYSICIAN ASSISTANT SERVICES

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

“Carrier”, an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a health maintenance organization organized under chapter 176G; an organization entering into a preferred provider

arrangement under chapter 176I; a contributory group general or blanket insurance for persons in the service of the commonwealth under chapter 32A; a contributory group general or blanket insurance for persons in the service of counties, cities, towns and districts, and their dependents under chapter 32B; the medical assistance program administered by the division of medical assistance pursuant to chapter 118E and in accordance with Title XIX of the Social Security Act or any successor statute; and any other medical assistance program operated by a governmental unit for persons categorically eligible for such program.

"Commissioner", the commissioner of insurance.

"Insured", an enrollee, covered person, insured, member, policyholder or subscriber of a carrier.

"Nondiscriminatory basis", a carrier shall be deemed to be providing coverage on a non-discriminatory basis if its plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a physician assistant which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other participating providers.

"Physician assistant", a person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician in accordance with sections 9C to 9H, inclusive, of chapter 112.

"Participating provider", a provider who, under the terms and conditions of a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to an insured with an expectation of receiving payment, other than coinsurance, co-payments or deductibles, directly or indirectly from the carrier.

“Primary care provider”, a health care professional qualified to provide general medical care for common health care problems who; (1) supervises, coordinates, prescribes, or otherwise provides or proposes health care services; (2) initiates referrals for specialist care; and (3) maintains continuity of care within the scope of practice.Section 2. The commissioner and the group insurance commission shall require that all carriers recognize physician assistants as participating providers subject to section 3 and shall include coverage on a nondiscriminatory basis to their insureds for care provided by physician assistants for the purposes of health maintenance, diagnosis and treatment. Such coverage shall include benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a physician assistant who is a participating provider and is practicing within the scope of his professional license to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.

Section 3. A participating provider physician assistant practicing within the scope of his license including all regulations requiring collaboration with a physician under section 9E of chapter 112, shall be considered qualified within the carrier's definition of primary care provider to an insured.

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

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

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

SECTION 40. The commissioner of public health, in consultation with the board of registration in medicine, the board of registration in nursing, the board of registration of physician assistants, and the board of registration in pharmacy, shall create an independent task force to examine the current regulatory structure governing professional relationships between physicians, nurse practitioners, and physician assistants to identify barriers to the coordination of primary care between physicians, nurse practitioners, and physician assistants and the barriers to expanding patient access to primary care through greater utilization of the nurse practitioner and physician assistant workforce, including the administrative simplification of prescribing practices. The task force shall issue a report of its study, including its recommendations and drafts of any legislation, if necessary, with the clerks of the Senate and House of Representatives and the joint committees on public health and health care financing within 1 year of the effective date of this act.

SECTION 41. There shall be a special commission to study and make recommendations on the opportunities and challenges faced by primary care physicians in community care settings. The commission shall consist of: the secretary of health and human services or her designee, who

shall serve as chair; the commissioner of health care finance and policy or his designee; 1 member appointed by the speaker of the house of representatives; 1 member appointed by the senate president; 1 representative of the Mass League of Community Health Centers; 1 representative of the Department of Family Medicine at UMass Medical School; 1 representative of the Department of Family Medicine at Boston Medical Center; 1 executive director of a community health center that currently participates in a family medicine residency training program; 1 executive director of a community health center that is the sponsoring organization and holds the credentials for the accredited training program; 1 representative of a health center with an interest in starting a residency program; 1 community health center physician who is a graduate of a community health center residency program; 1 residency director at a community health center; 1 current community health center resident; 1 representative of the Massachusetts Academy of Family Physicians; and 1 representative of the Massachusetts Chapter of the American Academy of Pediatrics.

The Commission's review shall include but not be limited to the following: (a) an analysis of the adequacy of the workforce in community health centers in the commonwealth; (b) the workforce needs at community health centers across the commonwealth within the context of the broader workforce shortage issues, and an evaluation on how community health centers can fill those slots; (c) the percentage of residents at health centers that eventually choose to practice in the community health center setting; (d) the contribution community health center residency programs have made in diversifying the physician pipeline and training physicians to address the medical needs of diverse populations; (e) opportunities to improve the training of primary care physicians in leadership roles and in practicing in a coordinated, team-based approach to primary care; (f) barriers to increasing the ability to train family physicians in community health centers

(g) the contributions the University of Massachusetts Medical School Learning Contract has made in increasing the primary care workforce in the commonwealth and recommendations for its improvement; (h) opportunities to develop mentorship programs for primary care physicians; (i) the sources of funding for community health center residency programs, and a determination on whether increased state investment will provide benefits for the commonwealth; (j) the feasibility and potential benefits of a supplemental Medicaid fee to community health centers engaged in 3-year residency programs; and, (k) the impact of national health reform on Massachusetts community health center residency programs, both new and existing, and an evaluation of any potential opportunities.

The commission shall report its findings, including its recommendations and drafts of any legislation, if necessary, with the clerks of the Senate and House of Representatives and the joint committees on public health and health care financing within 1 year after the effective date of this act.

SENATE DOCKET, NO. 245 FILED ON: 1/19/2011

SENATE . . . . . No. 483

The Commonwealth of Massachusetts

PRESENTED BY:

Stephen M. Brewer

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to electronic prescribing.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Stephen M. Brewer	*Worcester, Hampden, Hampshire, Franklin*

SENATE . . . . . No. 483

By Mr. Brewer, a petition (accompanied by bill, Senate, No. 483) of Stephen M. Brewer for legislation relative to electronic prescribing. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to electronic prescribing.

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

SECTION 1. The General Laws are hereby amended by inserting after chapter 111 the following chapter:-

CHAPTER 111O.

Massachusetts Electronic Prescribing Act

Section 1. Definitions.

A. Dispenser means a registered pharmacist or other legal entity licensed, registered or otherwise permitted by the jurisdiction in which the person practices or in which the entity is located to dispense drugs for human use by prescriptions.

B. Electronic Health Record (EHR) means the aggregate electronic record of health-related information on an individual that is created and gathered cumulatively across more than one health care organization and is managed and consulted by licensed clinicians and staff involved

in the individual's health and care. By these definitions, an EHR is an EMR with extramural interoperability, for example, ability to gather health information from other health systems.

C. Electronic Prescribing or Electronic Prescription (eRx) means the transfer of prescription information from the prescriber to the pharmacy by electronic means, instead of by paper, phone, or fax.

D. Electronic Transmission means transmission of information in electronic form or the transmission of the exact visual image of a document by way of electronic equipment.

E. Electronic Transmission Device means any mechanism used to facilitate the electronic transmission of a prescription by any individual authorized to prescribe in this state.

F. Patient means the individual for whom the prescriber makes a treatment decision.

G. Prescriber means an individual authorized under existing Massachusetts regulation to write a prescription for a patient under his or her direct care

H. Prescription Drug means a drug that may not be dispensed for human use without a prescription under the laws of the United States and of this State.

I. Prescription Drug Order means a prescription for a prescription drug in the state of Massachusetts as defined under

J. Prior Authorization means the process of obtaining prior approval from a health plan, pharmacy benefits manager or other entity for coverage of a prescription drug or other medical product or procedure.

Section 2. Electronic Prescribing Transmission Standards

A. The electronic transmission devices shall transmit information to prescribers and dispensers in accordance with Section 1860D-4(e)(2) of the Social Security Act, applied without regard to whether the patient is eligible for benefits under Title XVIII of the Social Security Act or whether the drug is a "covered Part D drug" within the meaning of the Social Security Act, as amended or any other covered drug.

Section 3. Federal Alignment

A. Electronic prescribing devices, software and hardware shall be designed in a manner to support meaningful use of electronic health records as required as part of the ARRA.

B. The state shall provide financial incentives to Medicaid providers as described in Section 4201 of the ARRA and pursue available Federal Financial Participation for these incentives and the state's administrative costs associated with the program.

C. The state board of pharmacy shall promulgate regulations aligning the state rules for the electronic transmission of prescriptions with the most recent regulations for such transmissions with the federal Drug Enforcement Administration [21 CFR Parts 1300, 1304, 1306 and 1311].

Section 4. Standards for Electronic Transmission of Prescriptions

A. All Prescription Drug Orders communicated by way of Electronic Transmission shall:

a. Be transmitted directly to a Pharmacist or Registered Pharmacy Technician in a licensed Pharmacy of the patient's choice with no intervening person having access to the Prescription Drug Order.

b. Identify the transmitter's phone number or any other suitable means to contact the transmitter for verbal and/or written confirmation, the time and date of transmission, and the

identity of the Pharmacy intended to receive the transmission, as well as any other information required by federal or state law;

c. Be transmitted by a prescriber or the designated agent of the prescriber as allowed under existing state law; and

d. Be deemed the original Prescription Drug Order, provided it meets the requirements of this subsection.

B. All Electronic Transmission Devices used to communicate a prescription to a Pharmacist or Registered Pharmacy Technician in a licensed pharmacy shall:

a. Allow any legal Prescription Drug Order to be written and entered into the device without limitations or interference, including a limited medication list from which a prescriber can select a medication on the device or non-clinical multiple messaging, prior to submission to a Pharmacist or Registered Pharmacy Technician in a licensed pharmacy;

b. Allow the prescription to be written through a neutral and open platform that does not use any means, program, or device, including, but not limited to, advertising, instant messaging, and pop up messaging, to influence or attempt to influence, through economic incentives or otherwise, the prescribing decision (as defined in clause (f) of the Definitions) of a health care professional at the point of care (as defined in clause (e) of the Definitions (i) Clause (b) shall apply if such means, program, or device is triggered by, initiated by, or is in specific response to, the input, selection, and/or act of a prescriber or his or her designated agent prescribing a covered outpatient drug or indicating which pharmacy a patient will visit to pick up the prescription or from which pharmacy the medication is preferred to be delivered.

c. In the event that the pharmacy a patient wishes to use is unable to receive the intended prescription, provide a system for printing the prescription for the patient to bring to the pharmacy that would prevent a duplicate prescription to be printed or transmitted once the prescription is final.

d. Allow for a written reminder to be provided to the patient at the time of the office visit pertaining to what prescription has been ordered electronically and to which pharmacy the prescription was sent.

e. Notwithstanding clause (b), electronic transmission devices may show information regarding a plan's formulary so long as— (i) All covered outpatient drugs and all pharmacies with a National Council for Prescription Drug Programs identification number (NCPDP #; in and out of network) available are readily disclosed to the prescriber; (ii) Nothing is designed to preclude or make more difficult the prescriber's or patient's selection of any particular pharmacy or covered outpatient drug; and (iii) An electronic prior authorization process for allowing approval of an exception to the plan formulary or other restriction is available on the device as described in Section 8 of this Act, providing real-time adjudication.

f. Allow a final review of the complete prescription before it is sent to the pharmacy.

g. As set forth in clause (b) above, be limited to messages to the prescriber and his or her staff that are consistent with the pharmaceutical label, substantially supported by scientific evidence, accurate, up to date, and fact-based, including a fair and balanced presentation of risks and benefits, and support for better clinical decision-making, such as, alerts to adverse events and access to formulary information. This information must be consistent with the U.S. Food and Drug Administration regulations for advertising pharmaceutical products and not be

selectively or competitively pushed to the prescriber. The distribution of such information must not diminish the patient's right to appeal.

h. The prescriber may authorize his or her designated agent to communicate a Prescription Drug Order orally or by way of Electronic Transmission to a Pharmacist or Registered Pharmacy Technician in a licensed Pharmacy, provided that the identity of the transmitting agent is included in the order as allowed under existing federal and state laws.

i. All electronic equipment for receipt of Prescription Drug Orders communicated by way of Electronic Transmission shall be maintained against unauthorized access as required by the HITECH Act.

j. Persons other than those bound by a confidentiality agreement or Business Associate Agreement pertaining to a patient's protected health information shall not have access to Pharmacy records containing Protected Health Information concerning the Pharmacy's patients as required by the Health Insurance Portability and Accountability Act.

Section 5. Alerts and Notifications

A. Alerts and messages provided to a prescriber must be meaningful to the appropriate delivery of care to a patient. Acceptable alerts and communications shall:

a. Be categorized or prioritized based on their clinical importance, including severity and likelihood of any adverse events;

b. Be individually suppressible by the prescriber, if they relate to either rare or minor adverse events;

c. Be able to be overridden by the prescriber so that the prescriber can prescribe his or her prescription drug of choice for the patient;

d. Display the date that the decision support rules underlying each alert or message were last updated, as well as a link to a general description of the decision support rules and the source of any financial support received in connection with the development of those rules; or

e. Clearly indicate whether the alert or other message relates to the prescription drug's safety or efficacy for the patient.

B. Information provided to a prescriber through an e-prescribing device shall not contain any material false statements or omissions. For purposes of this Act, a material false statement or omission is defined as an untrue statement of a material fact or an omission to state a material fact necessary in order to make the statements made under the circumstances in which they are made not misleading.

C. Any information provided to a prescriber through an e-prescribing device relating to the safety or efficacy of any drug (including any alerts or other messages) shall include a readily-accessible citation to any sources that support the accuracy of the information and link directly to FDA source information.

Section 6. Standards for Prior Authorization

A. Requests for prior authorization must utilize a standard format for such requests as defined by the Bureau of Insurance that is consistent with the Medicare Part D Coverage Determination Request Form.

B. Pursuant to paragraph A, key elements to be captured in prior authorization request form, whether electronic or paper, shall include:

a. Patient information data fields, including:

i. Patient name, date of birth, address, phone and gender;

ii. Patient health plan or prescription drug plan name; and

iii. Patient authorizing plan name and identification number.

b. Prescriber data fields, including:

i. Prescriber name, phone number and National Provider Identifier (NPI);

ii. Point of Contact (POC) name and phone number, if different than the prescriber; and

iii. Prescriber business address and fax number.

c. Pharmacy information data fields, if transmitting the prescription electronically:

i. Pharmacy name, phone number and Pharmacy National Provider Identifier;

ii. Pharmacy address.

d. Prescription drug information data fields, including:

i. Name, strength, quantity, dosing schedule of requested drug, day supply and refills authorized by prescriber;

ii. Other medications tried and explanation of results;

iii. Drug allergies; and

iv. Current clinical findings and management.

C. Specific information shall be provided to the prescriber pertaining to acceptable reasons for a prior authorization approval upon the request of the prescriber and information shall be provided to the prescriber if the prior authorization is rejected.

D. At a minimum, prior authorization shall be granted if the preferred drug:

a. Has been ineffective in the treatment of the patient's disease or medical condition, or

b. Based on both sound clinical or medical and scientific evidence another drug would result in better patient outcomes; or

c. Is expected to be ineffective based on the known relevant physical, genetic or mental characteristics of the patient and known characteristics of the prescription drug regimen, is likely to be ineffective or adversely affect the prescription drug's effectiveness or patient compliance; or

d. Has caused, or based on sound clinical evidence and medical and scientific evidence is likely to cause, an adverse reaction or other harm to the patient.

Section 7. Electronic Prior Authorization

A. Pursuant to Section 7 of this Act, an electronic prior authorization system shall:

a. Be aligned with the SCRIPT standard as set forth by the National Council for Prescription Drug Programs.

b. Be required as a part of devices, software and hardware systems that facilitate electronic submission of prescription drug orders;

c. Utilize a universal format for prior authorization requests to be developed by the Bureau of Insurance pursuant to Section 7 of this Act;

i. Notify patient's preferred pharmacy of pending prior authorization;

d. Provide specific feedback to the prescriber on acceptable and approvable reasons for approval of a prior authorization request for a prescription drug prescribed for a patient; and

e. Provide real-time feedback on the prior authorization request to the prescriber and the patient's preferred pharmacy that facilitates an explanation of benefits for the patient with information on how to appeal the denial of the requested medication.

B. An advisory committee to the Bureau of Insurance shall be formed to provide input to the Bureau of Insurance on the design of the universal prior authorization format, including a comparable paper form when an electronic prescribing device is not used. Members of the advisory committee shall include:

a. Two practicing physicians utilizing eRx on a routine basis

b. One practicing nurse practitioner or physician's assistant

c. One pharmacist practicing in an environment where eRx are commonly received

d. Two patient advocates

e. One representative of the health insurance industry

Section 8. This Act shall become effective 120 days after enactment.

SENATE DOCKET, NO. 765 FILED ON: 1/20/2011

SENATE . . . . . No. 485

The Commonwealth of Massachusetts

PRESENTED BY:

Gale D. Candaras

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act providing for patient education.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Gale D. Candaras	*First Hampden and Hampshire*
Angelo J. Puppolo, Jr.	*12th Hampden*
Timothy J. Toomey, Jr.	*26th Middlesex*
Benjamin Swan	*11th Hampden*

SENATE . . . . . No. 485

By Ms. Candaras, a petition (accompanied by bill, Senate, No. 485) of Gale D. Candaras, Angelo J. Puppolo, Jr., Timothy J. Toomey, Jr. and Benjamin Swan for legislation to provide for patient education. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 SENATE
 , NO. *533* OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act providing for patient education.

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

SECTION 1. Section 4, subsection c, of chapter 305 of the acts of 2008 is hereby amended by inserting at the end thereof the following:-- iv. facilitating the implementation and use of an interactive video patient education program.

SENATE DOCKET, NO. 1521 FILED ON: 1/21/2011

SENATE . . . . . No. 486

The Commonwealth of Massachusetts

PRESENTED BY:

Gale D. Candaras

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act concerning Medicaid and accountable care.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Gale D. Candaras	*First Hampden and Hampshire*
Jennifer E. Benson	*37th Middlesex*
Michael R. Knapik	*Second Hampden and Hampshire*
Denise Provost	*27th Middlesex*
Benjamin Swan	*11th Hampden*

SENATE . . . . . No. 486

By Ms. Candaras, a petition (accompanied by bill, Senate, No. 486) of Gale D. Candaras, Jennifer E. Benson, Michael R. Knapik, Denise Provost and others for legislation concerning Medicaid and accountable care. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act concerning Medicaid and accountable care.

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

1. a. The office of Medicaid and the executive office of health and human Services (EOHHS) shall establish a 3 year Medicaid urban-area accountable care organization (ACO) demonstration project as provided in this act. Urban ACOs approved for participation in the demonstration project shall be non-profit organizations formed through the voluntary participation of local hospitals, clinics, health centers, primary care physicians, nurses, and public health agencies for the purpose of improving the quality, capacity, and accessibility of the local health care system for Medicaid beneficiaries residing in the region. Payments for services reimbursed by the Medicaid fee-for-service program to providers participating in an approved urban ACO demonstration-project shall be made to the urban ACO and distributed to the participating providers in accordance with a written plan approved by the office of Medicaid and EOHHS. The urban ACO demonstration project shall be developed in consultation with managed care organizations and other vendors that contract with the Medicaid program to provide health care services to Medicaid beneficiaries.

b. In developing the written plan for distributing payments for services rendered to Medicaid patients by participating urban ACO demonstration project providers, the office of Medicaid and EOHHS, shall consider payment methodologies that promote care-coordination through multi-disciplinary teams, including payment for care of patients with chronic diseases and the elderly, and that encourage services such as: (i) patient or family education for patients with chronic diseases; (ii) home-based services; (iii) telephonic communication; (iv) group care; and (v) culturally and linguistically appropriate care. In addition, the payment system shall be structured to reward quality and improved patient outcomes, particularly for high cost, high needs patients. The payment system may not increase costs to Medicaid for patients served by an ACO demonstration project beyond the benchmark cost of care for those patients if they were not served by an ACO.

c. Nothing in this act shall be construed to limit the choice of a Medicaid beneficiary to access care for family planning services or any other type of healthcare services from a qualified health care provider who is not participating in the urban ACO demonstration project.

d. The office of Medicaid and EOHHS shall begin implementing the urban ACO demonstration project no later than July 1, 2011.

e. The office of Medicaid and EOHHS may certify up to five urban ACOs for participation in shared savings programs that promote accountability for patient populations residing in a designated urban area. Each such shared savings program will be operated as an urban ACO demonstration project designed to coordinate the provision of health care items and services paid for by Medicaid; to encourage investment in infrastructure and redesigned care processes for high quality and efficient service delivery; and facilitate the development of medical homes.

f. The office of Medicaid and EOHHS shall certify the urban ACO for participation in the urban ACO demonstration project following its determination that the urban ACO meets the requirements of this act and is designed to improve quality, cost, and access to health care by Medicaid beneficiaries. Urban ACO demonstration project applicants must agree to be accountable for the quality, cost, and overall access to care of the Medicaid beneficiaries residing in the designated urban area for a period of no less than 3 years. For purposes of this act, "designated urban area" shall mean a municipality or defined geographic area in which no fewer than 5,000 Medicaid beneficiaries reside, or other threshold that the office of Medicaid and EOHHS determine to be sufficient for reliable measurement of realized savings. EOHHS, in consultation with the office of Medicaid, shall adopt regulations establishing additional criteria required for participation in the urban ACO demonstration project.

g. An urban ACO demonstration project applicant must demonstrate that it is a non-profit entity that has established a mechanism for shared governance. The urban ACO must have a formal legal structure that allows the urban ACO to receive payments from Medicaid and any voluntarily participating Medicaid managed care organizations and distributes payments for quality improvement and for shared savings to participating ACO providers. Before receiving payments, the urban ACO must submit a written demonstration project application for review and approval by the office of Medicaid and EOHHS on how the payments will be used to improve quality, expand access, and reduce cost for patients living in geographic region of the ACO.

h. The Medicaid fee-for-service program shall remit payment to the participating urban ACO after approval by the office of Medicaid and EOHHS of the ACO's written demonstration project application for use of the funds and determination of the shared savings payment and approved

by the office of Medicaid and EOHHS using the methodology developed under Section 1(b) above.

i. The benchmark, against which savings are measured for each urban ACO, once established, may only be changed once every 3 years. A portion of realized shared savings from the urban ACOs may be used to offset increased health care expenditures by the Commonwealth of Massachusetts and support the continued operation of this urban ACO demonstration project. The percentage of shared savings to be (i) distributed to the urban ACO; (ii) kept by a participating Medicaid managed care organization or other third party payer; and (iii) kept by the Commonwealth of Massachusetts to support the administration of the program shall be determined at the start of the demonstration project and every 3 years.

j. The percentage-of shared savings to be distributed or kept as described herein shall be configured to: (i) ensure widespread participation by both urban communities and payers; (ii) ensure that the Commonwealth of Massachusetts realizes meaningful savings; and (iii) ensure that the demonstration project's annual administrative costs can be covered by year 3.

k. As used in this act:

"Primary care provider" includes, but is not limited to, a primary care physician, a registered nurse, a primary care professional medical practice, a federally qualified or community health center, and a primary care outpatient clinic operated by a general hospital.

2. The office of Medicaid shall, with assistance from EOHHS, evaluate the urban ACO demonstration project annually to assess: whether cost savings are achieved through implementation of the urban ACO demonstration project; the rates of health screening; the

outcomes and hospitalization rates for persons with chronic illnesses, and the hospitalization and readmission rates for the frail elderly.

3. The secretary of EOHHS shall apply for such state plan amendments or waivers as may be necessary to implement the provisions of this act and to secure federal financial participation for state Medicaid expenditures under the federal Medicaid program. The secretary of EOHHS may apply for participation in federal ACO demonstration projects that align with the goals of this act.

4. The secretary of EOHHS shall report annually to the governor, and to the legislature, on the findings and recommendations of the urban ACO demonstration project. After 3 years, if the secretary of EOHHS finds the urban ACO demonstration project was successful in reducing cost and improving the quality of care for Medicaid beneficiaries, the urban ACO demonstration project may be expanded to include additional underserved communities and shall become a permanent program.

5. The secretary of EOHHS shall adopt such rules and regulations as the commissioners deem necessary to carry out the provisions of this act.

6. This act shall take effect upon enactment and shall expire 3 years after the effective date, but the director of the office of Medicaid and the secretary of EOHHS may take such anticipatory administrative action in advance thereof as shall be necessary for the implementation of this act.

SENATE DOCKET, NO. 402 FILED ON: 1/19/2011

SENATE . . . . . No. 487

The Commonwealth of Massachusetts

PRESENTED BY:

Harriette L. Chandler

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act establishing telehealth.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Harriette L. Chandler	*First Worcester*

SENATE . . . . . No. 487

By Ms. Chandler, a petition (accompanied by bill, Senate, No. 487) of Harriette L. Chandler for legislation relative to the use of telemedicine to promote efficiency in the delivery of health care services. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 SENATE
 , NO. *534* OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act establishing telehealth.

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

SECTION 1. The purpose of this act shall be for the Commonwealth to recognize telehealth services as an effective means of monitoring and managing home health patients whose medical, functional and/or environmental needs can be appropriately and cost-effectively met through such technology. Reimbursable home telehealth will be fostered to ensure an increased communication with the patient, help early detection of chronic illness, prevent re-hospitalization and subsequent costs, enhance self-management and provide the patient an improved comprehension of his/her condition.

SECTION 2 Defnitions

For the purposes of this act, the following terms shall have the following meanings:

?Telehealth/telehealth technology,? includes the delivery of medical services and any diagnostic, treatment or health management assistance utilizing interactive audio, interactive video and/or interactive data transmission relative to the health care of a patient in a home care setting. Telehealth technology services do not include telephone conversations, electronic mail messages or facsimile transmissions.

?Certified home health agency,? includes those home health agencies that are approved for participation in the Medicare and Medicaid programs.

?Home care services,? are services provided to a home health patient by a certified home health agency.

SECTION 3. Notwithstanding any general or special law to the contrary, the executive office of health and human services is hereby directed, pursuant to section 7 of chapter 118G of the General Laws, to establish that health care services delivered by a certified home health agency through telehealth technology are reimbursable when provided to clients receiving home care services that are otherwise eligible for reimbursement under the Medicaid program. Recipients of telehealth services will be those that require home health services of unusually high frequency, urgency or duration and that have chronic medical conditions, including, but not limited to: congestive heart failure, diabetes, and/or chronic obstructive pulmonary disease.

SECTION 4. Rates of telehealth services shall reflect costs on a monthly basis in order to account for daily variation in the intensity and complexity of patients? telehealth service needs; provided that such rates shall further reflect the cost of the daily operation and provision of such services, which costs shall include the following functions undertaken by the participating certified home health agency:

Monitoring of patients vital signs;

Patient education;

Medication management;

Equipment maintenance and comprehension;

Review of patient trends and/or other changes in patient condition necessitating professional intervention; and

Other such activities as the executive office of health and human services deem necessary and appropriate to this section.

Reimbursement for telehealth services pursuant to this section shall be provided only in connection with Federal Food and Drug Administration-approved devices, and incorporated as part of the patient?s plan of care.

SECTION 5. The home health patient?s respective agency shall be responsible for the accuracy, maintenance and instruction on the usage of telehealth technology.

SECTION 6. This act shall become effective 60 days following its enactment.

SENATE DOCKET, NO. 1507 FILED ON: 1/21/2011

SENATE . . . . . No. 502

The Commonwealth of Massachusetts

PRESENTED BY:

Susan C. Fargo

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to administrative simplification in health insurance.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Susan C. Fargo	*Third Middlesex*

SENATE . . . . . No. 502

By Ms. Fargo, a petition (accompanied by bill, Senate, No. 502) of Susan C. Fargo for legislation relative to fair and equitable managed care contracting standards. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 SENATE
 , NO. *541* OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to administrative simplification in health insurance.

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

SECTION 1. Section 38 of chapter 118E of the General Laws is hereby amended by inserting at the end thereof of the following new paragraphs:-

Within 45 days after the receipt by the Division of completed forms for reimbursement to a physician who participates in a medical service program established pursuant to this chapter the Division shall (i) make payments for such services provided by the physician that are services covered under such medical assistance program and for which claim is made, or (ii) fully notify the provider in writing or by electronic means of any and all reason or reasons for nonpayment, or (iii) notify the provider within 15 days in writing or by electronic means of all additional information or documentation that is necessary to establish such physician's entitlement to such reimbursement. If the Division fails to comply with the provisions of this paragraph for any such completed claim, the Division shall pay, in addition to any reimbursement for health care

services provided to which the physician is entitled, interest on any unpaid amount of such benefits, which shall accrue beginning 45 days after the Division's receipt of request for reimbursement, or 15 days after the receipt of an electronic claim, at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the Division is investigating because of suspected fraud.

The division shall provide written guidelines to providers of medical services that participate in a medical assistance program established pursuant to this chapter setting forth a statement of its policies and procedures that is complete, detailed and specific with regard to what such providers must include in claims for reimbursement in order to qualify as a completed claim for reimbursement payment for which any such provider is entitled. Such guidelines shall identify all of the data and documentation that is to accompany each claim for reimbursement and shall identify all utilization review and other screening policies and procedures employed by the division in reviewing such claims submitted by a provider of medical services.

The division shall reimburse to providers of medical services that participate in a medical assistance program established pursuant to this chapter reasonable physician office practice expenses related to physician processing of prior authorizations for medications and procedures which require a decision or review by a physician or other licensed health professionals under the providers supervision or liability coverage.

SECTION 2. Section 108, subsection 4(c) of chapter 175 of the General Laws is hereby amended in the second sentence by striking out the words “forty five days” and inserting in place thereof the following:- “fifteen days”.

SECTION 3. Section 108 of chapter 175 of the General Laws is hereby amended by adding at the end thereof the following:

13. Notwithstanding any provision of any policy of insurance, a company shall reimburse to providers of medical services reasonable physician office practice expenses related to physician processing of prior authorizations for medications and procedures which require a decision or review by a physician or other licensed health professionals under the providers supervision or liability coverage.

SECTION 4. Section 110G of chapter 175 of the General Laws is hereby amended in the second sentence of the second paragraph by striking the words “forty five days” and inserting in place thereof the following:- “fifteen days,”

SECTION 5. Section 8 of chapter 176A of the General Laws is hereby amended in the first sentence of clause (e) by striking the words “within forty five days,”

SECTION 6. Section 7 of chapter 176B of the General Laws is hereby amended in the second sentence of the second paragraph by striking out the words “forty five days” and inserting in place thereof the following:- “fifteen days,”

SECTION 7. Section 7 of chapter 176B of the General Laws is hereby further amended by adding at the end thereof the following:-

Any agreement between a medical service corporation and a participating physician shall include reimbursement for reasonable physician office practice expenses related to physician processing of prior authorizations for medications and procedures which require a decision or

review by a physician or other licensed health professionals under the providers supervision or liability coverage.

SECTION 8. Section 6 of chapter 176G is hereby amended in the first sentence of the second paragraph by striking out the words “45 days” and inserting in place thereof the following:- “fifteen days,”

SECTION 9. Section 6 of chapter 176G is hereby further amended by adding at the end thereof the following:-

No contract between a participating provider of health care services and a health maintenance organization shall be issued or delivered in the commonwealth unless it includes reimbursement for reasonable physician office practice expenses related to physician processing of prior authorizations for medications and procedures which require a decision or review by a physician or other licensed health professionals under the providers supervision or liability coverage.

SECTION 10. Section 2 of chapter 176I is hereby amended in the first sentence of the third paragraph by striking the words “45 days” and inserting in place thereof the following: “fifteen days,”

SECTION 11. Section 2 of chapter 176I is hereby further amended by adding at the end thereof the following:-

No organization may enter into a preferred provider arrangement with one or more health care providers unless said written arrangement contains a provision requiring reimbursement for reasonable physician office practice expenses related to physician processing of prior

authorizations for medications and procedures which require a decision or review by a physician or other licensed health professionals under the providers supervision or liability coverage.

SECTION 12. Section 1 of chapter 176O of the General Laws is hereby amended by inserting after the definition of "concurrent review" the following:-

"contracting agent" , a covered entity engaged, for monetary or other consideration, in the act of leasing, selling, transferring, aggregating, assigning or conveying, a physician or physician panel to provide health care services to beneficiaries.

And further, by inserting after the definition of "covered benefit", the following:-

"covered entity" includes, but is not limited to, any entity responsible for payment or coordination of health care services, including but not limited to all entities that pay or administer claims on behalf of other entities.

And further, by inserting after the definition of "participating provider", the following:-

"payer", a self-insured employer, health care service plan, insurer, or other entity that assumes the risk for payment of claims or reimbursement for services provided by contracted physicians.

SECTION 13. Subsection (b) of Section 10 of chapter 176O of the General Laws is hereby amended by adding the following paragraphs:

(4) a requirement that physician group budgets be based on an accepted per member per month cost determined y actuarial input from a collaboration of representatives including physicians, business groups, employers, carriers and the Division of Insurance.

(5) a requirement that reinsurance amounts be determined according to an actuarial standard estimate of catastrophic events in a provider unit.

(6) a requirement that carriers provide the physician or physician group with detailed expense descriptions, including but not limited to member name, dates of service, primary care and referring physician information, the physician and/or facility performing the services, amount paid, and, where applicable, amount withheld. Physicians should also receive specific information on the company's provider units and/or contracted physicians reconciliation process so that the provider can review the information at least three months prior to the corporation's declaring the provider unit above, under, or at budget, and provided further that that physicians and physician entities have immediate access to initial claims reports when the claims requests are received by the health insurance plan.

(7) a provision permitting the provider to refuse participation in one or more such other plans at the time the contract is executed without affecting the provider's status as a member of or for eligibility in the plan which is the subject of such contract or other plans."

(8) a prohibition against modification of the contract without the express, written consent of all parties.

(9) a requirement that claims which may involve other carriers or future settlements, including but not limited to auto accidents involving legal cases, be extracted from year end budget and settlement information

(10) a prohibition against representatives of health insurance carriers from initiating communication with members or their families regarding treatment options and code stuatues without a physicians knowledge or presence.

SECTION14. Section 10 of chapter 176O of the General Laws is herby amended by inserting after subsection (c) the following subsections:-

(d) (1) A contracting agent shall be registered with the Division of Insurance. Provided further that all contracts between a physician and a contracting agent shall comply with all of the following requirements:

(a) Contain within the contract itself all material terms consistent with the general laws.

(b) Clearly and in a separate section, name any payer eligible to claim a discounted rate.

1. Any payers seeking eligibility to claim a discounted rate, directly or indirectly, subsequent to the original execution of the contract must be added to the contract through a separate amendment to the contract that is signed by the physician.

2. Any amendment naming additional payers shall be presented to the physician for signature ninety (90) days prior to any anticipated disclosure, lease, sale, transfer, aggregation, assignment, or conveyance of the physician’s discounted rate.

(c) Identify and highlight all amendments made to the contract.

(d) Contain a provision identifying the right of the physician to affirmatively opt in and/or opt out of any agreements to lease, sell, transfer, aggregate, assign or convey a physician panel and associated discounts without penalty, sanction, or retaliation of any kind.

(e) Contain provisions informing the physician of his or her contracting and payment rights, as specified in this section and all other relevant provisions of the general laws.

(f) Contain a provision fully disclosing any access fee or other remuneration the contracting agent may receive and the specific benefits and service the contracting agent will provide.

(g) Contain a provision that requires the contracting agent to obligate any payer or covered entity, through contract, to not further disclose, lease, sell, transfer, aggregate, assign or convey the physician panel and associated discounts to any other payer or entity; and

(h) Contain a provision that requires upon the termination of the physician-contracting agent contract, the contracting agent to notify each payer or covered entity that the payer or covered entity, is no longer authorized to:

1. Access the physician's discounted rate; or

2. Disclose, lease, sell, transfer, aggregate, assign, or convey the physician's discounted rate.

(2) A contracting agent that proposes to sell, lease, assign, transfer or convey a physician's name, contracted rate or any other information must have a direct contract with the physician.

(3) A contracting agent shall ensure through contract terms that all payers to which it has leased, sold, transferred, aggregated, assigned or conveyed a physician panel and its associated discounts comply with the underlying contract between the contracting agent and the physician and pay the physician pursuant to the rates of payment and methodology set forth in the underlying contract.

(4) A contracting agent shall not lease, sell, transfer, aggregate, assign or convey its physician panel and associated discounts or any other contractual obligation to any entity that is not a payer.

(5) The contract between the contacting agent and physician will neither authorize nor require the physician to consent to the sale of his or her name and contracted rates for use with more than a single product or line of business.

(6) The contract between the contracting agent and the physician will neither authorize nor require the physician to consent to the sale of his or her name and contracted rate more than once.

(7) After receiving information from a contracted physician that a payer to whom a contracting agent has leased, sold, transferred, aggregated, assigned or conveyed its physician panel and associated discounts is not complying with the terms of the underlying contract, including, but not limited to, statutory requirements for timely and accurate payment of claims, and the contracted physician has fulfilled the appeal or grievance process described in the underlying agreement, if any, without satisfaction, the contracting agent shall, within 45 days, do at least one of the following:

(a) Ensure the payer causes correct payment to be made to the physician.

(b) Ensure the payer otherwise complies with the terms of the underlying contract or terminate the contracting agent's agreement with the payer.

(c) Assume direct responsibility for the payment of the claim in question by paying the physician the amount owed under the contract and in the manner required by general laws.

(8) A contracting agent shall require those payers and covered entities that are by contract eligible to claim a physician's contracted rates to cease claiming entitlement to those rates upon termination of the underlying contract between the contracting agent and the physician or upon

termination of the physician's authorization for the payer to pay the contracted reimbursement rate as permitted under the terms of the contract between the contracting agent and the physician.

(9) Any explanation of benefits and/or remittance advice issued in the Commonwealth after the effective date of this act, in electronic or paper format, shall include the identity of the entity authorized to have leased, sold, transferred, aggregated, assigned or conveyed the physician's name and associated discount.

(10) After the effective date of this act, a payer, or any representative of the payer, processing claims or claims payments, shall clearly identify, in electronic or paper format, on the explanation of benefits and/or remittance advice, the entity assuming financial risk for services and the identity of the contracting agent through which the payment rate and any discount are claimed. A copy of the underlying contract must be provided to the physician upon request.

(11) After the effective date of this act, where the covered entity, contracting agent, or payer issues member or subscriber identification cards, the cards shall, in a clear and legible manner, identify any third-party entity, including any contracting agent, responsible for paying claims and any third-party entity, including a contracting agent, whose contract with a payer controls or otherwise affects reimbursement for claims filed pursuant to the subscriber contract.

(12) No payer, payer representative, administrator of claims payment, or other third party acting on behalf of a payer shall be eligible to claim or otherwise proffer a physician's specific contracted rate for services except to the extent that the rate is based on the contract that directly controls payment for services provided to that patient and is reflected on the explanation of benefits and/or remittance advice and on any patient identification card issued to the patient.

(13) Nothing in the contract between the contracting agent and the physician shall supersede the provisions of this act.

(14) In coordination with relevant state law, no covered entity may retaliate against a physician for exercising the right of action provided under this Act.

(15) The Division of Insurance shall adopt regulations as necessary for the implementation and administration of this Act. Upon finding a contracting agent, insurer, or other entity in violation of this Act, the Commissioner of Insurance may issue a cease and desist order to prevent violation of this Act and shall issue fines and penalties of no less than $1,000 per violation. The Division shall adopt an administrative remedy process for parties to pursue their rights, including but not limited to the recoupment of payment lost, by a physician, due to an unauthorized agreement to lease, sell, transfer, aggregate, assign or convey a physician panel and associated discount arrangement in violation with this Act.

(16) Nothing in this Act prohibits or limits any claim or action for a claim that the physician has against a covered entity or contracting agent. All applicable administrative fines and penalties apply.

(17) If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

SENATE DOCKET, NO. 105 FILED ON: 1/18/2011

SENATE . . . . . No. 505

The Commonwealth of Massachusetts

PRESENTED BY:

Jennifer L. Flanagan

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act to provide access to patient protection services for all Massachusetts citizens.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Jennifer L. Flanagan	*Worcester and Middlesex*
Jennifer E. Benson	*37th Middlesex*
Susan C. Fargo	*Third Middlesex*

SENATE . . . . . No. 505

By Ms. Flanagan, a petition (accompanied by bill, Senate, No. 505) of Jennifer L. Flanagan, Jennifer E. Benson and Susan C. Fargo for legislation to provide access to patient protection services for all Massachusetts citizens. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act to provide access to patient protection services for all Massachusetts citizens.

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

SECTION 1. Notwithstanding the provision of any general or special law to the contrary, every citizen of Massachusetts shall have access to the standards and procedures established under Sections 13, 14, 15, and 16 of Chapter 176O. Such standards shall be administered and enforced by the Office of Patient Protection established by Section 217 of Chapter 111.

The Executive Office of Health and Human Services shall request Waivers from any federal laws or regulations which impede the effective implementation of this Act.

SENATE DOCKET, NO. 1793 FILED ON: 1/21/2011

SENATE . . . . . No. 508

The Commonwealth of Massachusetts

PRESENTED BY:

Jennifer L. Flanagan

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to acute care hospital financial reports .

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Jennifer L. Flanagan	*Worcester and Middlesex*
Bruce E. Tarr	*First Essex and Middlesex*
Demetrius J. Atsalis	*2nd Barnstable*
Jennifer E. Benson	*37th Middlesex*
James B. Eldridge	*Middlesex and Worcester*
Kimberly N. Ferguson	*1st Worcester*
Sheila C. Harrington	*1st Middlesex*

SENATE . . . . . No. 508

By Ms. Flanagan, a petition (accompanied by bill, Senate, No. 508) of Jennifer L. Flanagan, Bruce E. Tarr, Demetrius J. Atsalis, Jennifer E. Benson and other members of the General Court for legislation relative to acute care hospital financial reports. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to acute care hospital financial reports .

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

Section 1. Chapter 118G of the General Laws is hereby amended by inserting after section 41, the following section:-

Section 42. Acute care hospitals licensed by the Department of Public Health must submit quarterly reports to the Division of Health Care Finance and Policy which outline the financial health and capacity of the hospital and/or of the network which owns said hospital. This report must include specific profit and loss information for hospital departments, including but not limited to non direct health care services, cardiac care, cancer care, orthopedics, maternity and behavioral health. The department shall promulgate regulations relative to what should be included in these reports.

SENATE DOCKET, NO. 1023 FILED ON: 1/20/2011

SENATE . . . . . No. 523

The Commonwealth of Massachusetts

PRESENTED BY:

Michael O. Moore

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act improving access to coverage for medicaid beneficiares.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Michael O. Moore	*Second Worcester*

SENATE . . . . . No. 523

By Mr. Moore, a petition (accompanied by bill, Senate, No. 523) of Michael O. Moore for legislation to improve access to coverage for medicaid beneficiaries. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act improving access to coverage for medicaid beneficiares.

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

SECTION 1. Chapter 118E of the General Laws is hereby amended by adding the following new section:

Section 62. - The Executive Office of Health and Human Services shall discontinue membership in the MassHealth fee-for-service program and primary care clinician plan, and shall begin to enroll all members meeting eligibility requirements, as established pursuant to applicable federal and state law and regulation, into a Medicaid managed care organization that has contracted with the commonwealth to deliver such managed care services, in accordance with the enrollment and assignment process for other eligible categories and at the appropriate levels of premium.

SECTION 2.

This act shall take effect on January 1, 2012.

SENATE DOCKET, NO. 1055 FILED ON: 1/20/2011

SENATE . . . . . No. 525

The Commonwealth of Massachusetts

PRESENTED BY:

Michael O. Moore

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to transparency in hospital margins..

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Michael O. Moore	*Second Worcester*

SENATE . . . . . No. 525

By Mr. Moore, a petition (accompanied by bill, Senate, No. 525) of Michael O. Moore for legislation relative to transparency in hospital margins. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to transparency in hospital margins..

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

SECTION 1. Chapter 118G of the General Laws is hereby amended by inserting after section 4 the following section:-

Section 4A. If in any fiscal year, an Acute Hospital, as defined in this chapter, reports to the division an operating margin that exceeds 6 percent, the division shall hold a public hearing within 60 days. The Acute Hospital shall submit testimony on its overall financial condition and the continued need to sustain an operating margin that exceeds 6 percent. The Acute Hospital shall also submit testimony on efforts the Acute Hospital is making to advance health care cost containment and health care quality improvement; and whether, and in what proportion to the total operating margin, the Acute Hospital will dedicate any funds to reducing health care costs. The division shall review such testimony and issue a final report on the results of the hearing. In implementing the requirements of this Section, the Division shall utilize data collected by hospitals pursuant to the requirements of Section 53 of Chapter 288 of the Acts of 2010.

SENATE DOCKET, NO. 1682 FILED ON: 1/21/2011

SENATE . . . . . No. 533

The Commonwealth of Massachusetts

PRESENTED BY:

Richard T. Moore

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to equitable funding for the Division of Health Care Finance and Policy.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Richard T. Moore	*Worcester and Norfolk*

SENATE . . . . . No. 533

By Mr. Moore, a petition (accompanied by bill, Senate, No. 533) of Richard T. Moore for legislation relative to equitable funding for the division of health care finance and policy. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 SENATE
 , NO. *556* OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to equitable funding for the Division of Health Care Finance and Policy.

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

SECTION 1: Notwithstanding any general or special law to the contrary, the annual assessment that is applied to each acute care hospital to fund the operations of the Division of Health Care Finance and Policy, pursuant to section 5 of Chapter 118G of the General laws shall not exceed each hospital's total annual amount that was assessed and collected by the Division in state fiscal year 2011.

SECTION 2: The Executive Office of Health and Human Services shall prepare a report which sets forth recommendations for the establishment of new funding options to support the operations of the Division of Health Care Finance and Policy, pursuant to section 5 of chapter 118G of the General Laws. The recommendations shall take into consideration the expanded role, responsibility and scope of work undertaken by the Division of Health Care

Finance and Policy since the development of the current formula. The report shall include a specific recommendation (i) for reducing the expenses of the Division through added economies and efficiencies of operation and elimination of lower priority functions and activities, and (ii) for funding sources that more accurately reflects the current role of the Division and minimizes the expense to the hospital community. The Executive Office of Health and Human Services shall be directed to deliver its report and recommendations to the House and Senate Committees on Ways and Means and the Joint Committee on Health Care Financing by December 1, 2011.

SENATE DOCKET, NO. 1772 FILED ON: 1/21/2011

SENATE . . . . . No. 538

The Commonwealth of Massachusetts

PRESENTED BY:

Richard T. Moore

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act to promote electronic transmission of health care transactions.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Richard T. Moore	*Worcester and Norfolk*

SENATE . . . . . No. 538

By Mr. Moore, a petition (accompanied by bill, Senate, No. 538) of Richard T. Moore for legislation to promote electronic transmission of health care transactions. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 SENATE
 , NO. *566* OF 2009-2010.]

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act to promote electronic transmission of health care transactions.

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

SECTION 1. Chapter 176O of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by inserting after section 20, the following new section:

Section 21. Beginning January 1, 2010, all hospitals, physician practices and carriers shall conduct the following transactions electronically:

1.Eligibility for a health plan transaction, as described under Code of Federal Regulations, title 45, part 162, subpart L;

2.Health care payment and remittance advice transaction, as described under Code of Federal Regulations, title 45, part 162, subpart P;

3.Health care claims or equivalent encounter information transaction, as described under Code of Federal Regulations, title 45, part 162, subpart K;

SENATE DOCKET, NO. 1840 FILED ON: 1/21/2011

SENATE . . . . . No. 541

The Commonwealth of Massachusetts

PRESENTED BY:

Richard T. Moore

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to strengthening the DoN Program.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Richard T. Moore	*Worcester and Norfolk*
Geraldo Alicea	*6th Worcester*
Benjamin B. Downing	*Berkshire, Hampshire, and Franklin*
James B. Eldridge	*Middlesex and Worcester*

SENATE . . . . . No. 541

By Mr. Moore, a petition (accompanied by bill, Senate, No. 541) of Richard T. Moore, Geraldo Alicea, Benjamin B. Downing and James B. Eldridge for legislation relative to strengthening the DoN Program. Health Care Financing.

[SIMILAR MATTER FILED IN PREVIOUS SESSION
SEE
 SENATE
 , NO. *2414* OF 2009-2010.]

The Commonwealth of Massachusetts

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In the Year Two Thousand Eleven

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An Act relative to strengthening the DoN Program.

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

SECTION 1. Section 25B of chapter 111 of the General Laws, as appearing in the 2008 official edition, is hereby amended by deleting the definition of "Expenditure minimum with respect to capital expenditures" and replacing it with the following new language:

"Expenditure minimum with respect to substantial capital expenditures", with respect to expenditures and acquisitions made by or for: (1) acute care hospitals and comprehensive cancer centers as defined in section 1 of chapter 118G, only, $7,500,000, except that expenditures for, or the acquisition of, major movable equipment not otherwise defined by the department as new technology or innovative services shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; and (2) health care facilities, other than acute care hospitals, and facilities subject to licensing under chapter 111B, with respect to: (a)

expenditures for, or the acquisition of, medical, diagnostic or therapeutic equipment, $400,000; and (b) all other expenditures and acquisitions, $800,000; provided, however, that expenditures for, or the acquisition of, any replacement of medical, diagnostic or therapeutic equipment defined as new technology or innovative services for which a determination of need has issued or which was exempt from determination of need, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum; provided further, that expenditures and acquisitions concerned solely with outpatient services other than ambulatory surgery, not otherwise defined as new technology or innovative services by the department, shall not require a determination of need and shall not be included in the calculation of the expenditure minimum, unless the expenditures and acquisitions are at least $7,500,000, in which case a determination of need shall be required. Notwithstanding the above limitations, acute care hospitals only may elect at their option to apply for determination of need for expenditures and acquisitions less than the expenditure minimum.

SECTION 2. Section 25C of Chapter 111 of the General Laws is hereby amended by striking the first paragraph and inserting in place thereof the following:

Section 25C. Notwithstanding any contrary provisions of law, except as provided in section twenty-five C1/2, no person or agency of the commonwealth or any political subdivision thereof shall make substantial capital expenditures for construction of a health care facility or substantially change the service of such facility unless there is a determination by the department that there is need therefore, followed by review and approval by the state auditor, pursuant to section 18 of Chapter 11. No such determination of need shall be required for any substantial capital expenditure for construction or any substantial change in service which shall be related solely to the conduct of research in the basic biomedical or applied medical research areas, and

shall at no time result in any increase in the clinical bed capacity or outpatient load capacity of a health care facility, and shall at no time be included within or cause an increase in the gross patient service revenue of a facility for health care services, supplies, and accommodations, as such revenue shall be defined from time to time in accordance with section thirty-one of chapter six A. Any person undertaking any such expenditure related solely to such research which shall exceed or may reasonably be regarded as likely to exceed one hundred and fifty thousand dollars or any such change in service solely related to such research, shall give written notice thereof to the department and the division of health care finance and policy at least sixty days before undertaking such expenditure or change in service. Said notice shall state that such expenditure or change shall be related solely to the conduct of research in the basic biomedical or applied medical research areas, and shall at no time be included within or result in any increase in the clinical bed capacity or outpatient load capacity of a facility, and shall at no time cause an increase in the gross patient service revenue, as defined in accordance with said section thirty-one of said chapter six A, of a facility for health care services, supplies and accommodations. Notwithstanding the preceding three sentences, a determination of need shall be required for any such expenditure or change if the notice required by this section is not filed in accordance with the requirements of this section, or if the department finds, within sixty days after receipt of said notice, that such expenditure or change will not be related solely to research in the basic biomedical or applied medical research areas, or will result in an increase in the clinical bed capacity or outpatient load capacity of a facility, or will be included within or cause an increase in the gross patient service revenues of a facility. A research exemption granted under the provisions of this section shall not be deemed to be as evidence of need in any determination of need proceeding.

SECTION 3. Chapter 11 of the General Laws is hereby amended by inserting after section 17 the following new section:

Section 18: (a) The state auditor shall have jurisdiction to review all applications for determination of need filed pursuant to Section 25C of Chapter 111. Following initial approval by the department of public health, all determination of need applications shall be sent to the department of the state auditor for review and approval.

(b) The state auditor shall approve a project only if the state auditor determines that the project will not have an adverse effect on competition in the health care market and shall give due consideration to whether the project is likely to increase rates of payment to providers, whether the project is likely to result in an inappropriate increase in utilization of health care services, and whether the proposed service could be provided by a community based provider.

(c) The state auditor shall report to the department of public health the results of said review no later than four months after receiving notice of approval by the department. No project shall be approved by the department of public health without approval of the state auditor.

SECTION 4. Chapter 111, as appearing in the 2008 official edition, is hereby further amended by deleting section 53G and replacing it with the following new language:

Section 53G. Any entity that is certified or seeking certification as an ambulatory surgical center by the Centers for Medicare and Medicaid Services for participation in the Medicare program shall be a clinic for the purpose of licensure under section 51, and shall be deemed to be in compliance with the conditions for licensure as a clinic under said section 51 if it is accredited to provide ambulatory surgery services by the Accreditation Association for Ambulatory Health Care, Inc., the Joint Commission on Accreditation of Healthcare

Organizations, the American Association for Accreditation of Ambulatory Surgery Facilities or any other national accrediting body that the department determines provides reasonable assurances that such conditions are met. No original license shall be issued pursuant to said section 51 to establish any such ambulatory surgical clinic unless there is a determination by the department that there is a need for such a facility. For purposes of this section, "clinic" shall include a clinic conducted by a hospital licensed under said section 51 but not by the federal government or the commonwealth. The department shall promulgate regulations to implement this section.

SECTION 5. Section 25C of Chapter 111 of the General Laws is amended by inserting after the first paragraph the following new paragraph:

"The Department shall conduct a statewide planning initiative for the purposes of studying and coordinating the availability and delivery of health care services within the commonwealth. The initiative shall examine the current supply of inpatient and outpatient services, and technologies and develop a plan for the provision of new services, beds, technologies, and structural expansions throughout the commonwealth, and develop a plan for the continued role of community hospitals and health centers within the commonwealth. The Department shall utilize this plan in its evaluation of all applications for a determination of need, as required by this section, in order to determine whether the proposed expansion construction, or acquisition of health care facilities or services is needed in the Commonwealth, or whether the proposed expansion construction, or acquisition of health care facilities or services will unnecessary duplicate ongoing services and increase health care costs in the Commonwealth."

SECTION 6. Section 25C of Chapter 111 of the General Laws is amended by inserting at the end of the section the following new paragraph:

"Any hospital seeking to expand its emergency department shall file a determination of need with the department. In addition to the information required pursuant to this section, the department shall require hospitals seeking emergency department expansions to demonstrate that prior to filing a determination of need application, the hospital has implemented measures to reduce emergency room overcrowding. The department shall promulgate regulations defining the measures hospitals may take to reduce emergency room overcrowding."

Section 25C of Chapter 111 of the General Laws is further amended by inserting at the end of the 2nd paragraph the following language:

"Each person or agency of the commonwealth or any political subdivision thereof filing a determination of need to acquire new technology shall, in addition to the information required by this section, file with the department documentation of programs implemented by the health care facility designed to ensure utilization of all new technology in a manner that is consistent with state and national guidelines. The department shall annually publish a list of state and national guidelines governing the utilization of new technology. The department shall promulgate regulations necessary to enforce this section."

Section 25C of Chapter 111 of the General Laws is further amended by deleting the last sentence of the 7th paragraph and replacing it with the following new language:

"A reasonable fee, established by the department, shall be paid upon the filing of such application. The fee shall be adjusted annually as necessary to accommodate the volume of new applications."

Section 3 of Chapter 17 of the General Laws is hereby amended by deleting Section 3 in its entirety and replacing it with the following new language:

Section 3. (a) There shall be a public health council to advise the commissioner of public health and to perform other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 17 members appointed for terms of 6 years under this section. The commissioner may designate 1 of the members as vice chairperson and may appoint subcommittees or special committees as needed.

(b) Four of the members shall be appointed by the governor: 1 shall be appointed from among the chancellor of the University of Massachusetts Medical School and a list of 3 nominated by said chancellor; 1 shall be appointed from among the dean of the University of Massachusetts Amherst School of Public Health or Health Sciences and a list of 3 nominated by said dean; 1 shall be appointed from among the heads of the non-public schools of medicine in the commonwealth or their nominees; and 1 shall be appointed from among the heads of the non-public schools or programs in public health in the commonwealth or their nominees.

(c) Four of the appointed members shall be providers of health services, appointed by the governor: 1 of whom shall have expertise in acute care hospital management; 1 of whom shall have expertise in long term care management; 1 of whom shall have expertise in home or community-based care management, and 1 of whom shall have expertise in the practice of primary care medicine or public health nursing.

(d) Six of the appointed members shall be non-providers: 1 shall be appointed by the secretary of elder affairs; 1 shall be appointed by the secretary of veterans' services; 1 shall be appointed by the governor from a list of 3 nominated by Health Care For All, Inc.; 1 shall be

appointed by the governor from a list of 3 nominated by the Coalition for the Prevention of Medical Errors, Inc.; 1 shall be appointed by the governor from a list of 3 nominated by the Massachusetts Public Health Association; and 1 shall be appointed by the governor from a list of 3 nominated by the Massachusetts Community Health Worker Network. Whenever an organization nominates a list of candidates for appointment by the governor under this subsection, the organization may nominate additional candidates if the governor declines to appoint any of those originally nominated.

(e) Three of the appointed members shall be payers of health care, appointed by the governor: 1 shall represent a health plan licensed in the Commonwealth; 1 shall represent small businesses; and one shall represent large businesses.

(f) For purposes of this section, "non-provider" shall mean a person whose background and experience indicate that he is qualified to act on the council in the public interest; who, and whose spouse, parents, siblings or children, have no financial interest in a health care facility; who, and whose spouse has no employment relationship to a health care facility, to a nonprofit service corporation established under chapters 176A to 176E, inclusive, or to a corporation authorized to insure the health of individuals; and who, and whose spouse, is not licensed to practice medicine.

(g) Upon the expiration of the term of office of an appointive member, his successor shall be appointed in the same manner as the original appointment, for a term of 6 years and until the qualification of his successor. The members shall be appointed not later than 60 days after a vacancy. The council shall meet at least once a month, and at such other times as it shall determine by its rules, or when requested by the commissioner or any 4 members. The

appointive members shall receive $100 per day that the council meets, and their reasonably necessary traveling expenses while in the performance of their official duties.

SENATE DOCKET, NO. 908 FILED ON: 1/20/2011

SENATE . . . . . No. 542

The Commonwealth of Massachusetts

PRESENTED BY:

Marc R. Pacheco

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to the composition of the health care quality and cost council.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Marc R. Pacheco	*First Plymouth and Bristol*
Karen E. Spilka	*Second Middlesex and Norfolk*
Daniel A. Wolf	*Cape and Islands*
Katherine M. Clark	*Middlesex and Essex*

SENATE . . . . . No. 542

By Mr. Pacheco, a petition (accompanied by bill, Senate, No. 542) of Marc R. Pacheco, Karen E. Spilka, Daniel A. Wolf and Katherine M. Clark for legislation relative to the composition of the health care quality and cost council. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to the composition of the health care quality and cost council.

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

SECTION 1. Section 16K of Chapter 6A of the General Laws is hereby amended in subsection (b) by striking in the first sentence the word "16" and inserting in its place thereof the word "17" and shall be further amended in the same subsection by inserting after the phrase, "and 1 representative of a non-governmental purchaser of health insurance." The following:--

"and 1 representative of a not for profit community hospital recommended by the board of directors of the Massachusetts Council of Community Hospitals."

SENATE DOCKET, NO. 915 FILED ON: 1/20/2011

SENATE . . . . . No. 543

The Commonwealth of Massachusetts

PRESENTED BY:

Marc R. Pacheco

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act relative to patient safety.

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Marc R. Pacheco	*First Plymouth and Bristol*
Cory Atkins	*14th Middlesex*
Sal N. DiDomenico	*Middlesex, Suffolk, and Essex*
Katherine M. Clark	*Middlesex and Essex*
Cynthia S. Creem	*First Middlesex and Norfolk*
Dennis A. Rosa	*4th Worcester*
James B. Eldridge	*Middlesex and Worcester*
Patricia D. Jehlen	*Second Middlesex*
Mark C. Montigny	*Second Bristol and Plymouth*
Robert L. Hedlund	*Plymouth and Norfolk*
Thomas P. Kennedy	*Second Plymouth and Bristol*
Sonia Chang-Diaz	*Second Suffolk*
Michael O. Moore	*Second Worcester*
Daniel A. Wolf	*Cape and Islands*

SENATE . . . . . No. 543

By Mr. Pacheco, a petition (accompanied by bill, Senate, No. 543) of Marc R. Pacheco, Cory Atkins, Sal N. DiDomenico, Katherine M. Clark and other members of the General Court for legislation relative to patient safety. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act relative to patient safety.

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

SECTION 1. Chapter 118G of the General laws, as appearing in the 2004 Official Edition, is hereby amended by adding the following new section:-

Section 28:

(a) The division shall require hospitals, nursing homes, chronic care and rehabilitation hospitals, other specialty hospitals, clinics, including mental health clinics, all other health care institutions, organizations and corporations licensed or registered by the department of public health and health maintenance organizations as defined in chapter 176G to annually report appropriate data to the division. This data will be posted and made available to the general public via the internet and include but not be limited to:

(i) measures which differentiate between severity of patient illness, readmission rates, length of stay, patient/family satisfaction with care, nurse satisfaction and nurse vacancy rates;

(ii) indicators of the nature and amount of nursing care directly provided by licensed nurses including, but not limited to, the actual and the average ratio of registered nurses to patients or residents and the actual and the average skill mix ratio of licensed and supervised unlicensed personnel to patients or residents, and statistics as defined by the National Quality Forum (NQF) and/or the Center for Medicare and Medicaid Services (CMS) on the number of falls, number of incidents of failure to rescue, number of health care acquired infections, including sepsis and pneumonia, and number of medication errors.

(iii) documentation of defined nursing interventions such as clinical assessment by a licensed provider, pain measurement and management, skin integrity management, patient education and discharge planning; and

(iv) documentation of patient safety measures such as restraint checks, seizure precautions and suicidal precautions, to enable purchasers of group health insurance policies and health care services and for the public at large to make meaningful financial and quality of care comparisons.

(b) The division shall consult with interested parties, including but not limited to; the group insurance commission, the Massachusetts nurses association, the Massachusetts health data consortium, the Massachusetts hospital association, the public health council, Massachusetts senior action council, associated industries of Massachusetts, a large labor union, the division of medical assistance, the board of registration in nursing, the division of insurance, the Massachusetts association of health maintenance organizations, and a national council of quality assurance accreditation expert to develop methodologies for collecting and reporting data

pursuant to this section and to plan for its use and dissemination to culturally diverse populations.

(c) Subject to the provisions of section 2(c) of chapter 66A, information collected by the division pursuant to this section shall be made available annually in the form of printed reports and through electronic medium derived from raw data and/or through computer-to-computer access. All personal data shall be maintained with the physical safeguards enumerated in said chapter.

SECTION 2. Section 70E of Chapter 111 of the General Laws is hereby amended by striking out in line 89 the word “and”.

SECTION 3. Said section 70E of said Chapter 111, as so appearing, is hereby further amended by striking out in line 99 the word “foregoing.” and adding, the following words “foregoing; and”.

SECTION 4. Said section 70E of said Chapter 111, as so appearing, is hereby further amended by adding at the end thereof the following new subsection:—

(o) upon request, to receive from a duly authorized representative of the facility, disclosure of nursing sensitive outcome data as defined by NQF and/or CMS for statistics including but not limited to, the actual and the average ratio of registered nurses to patients or residents and the actual and the average skill mix ratio of licensed and supervised unlicensed personnel to patients or residents, the number of falls, the number of incidents of failure to rescue, the number of health care acquired infections, including sepsis and pneumonia, and the number of medication errors, and further, upon request, to receive from said duly authorized representative information regarding the educational preparation and length of employment of

said facility's nursing staff, as well as information on nurse satisfaction and nurse vacancy rates, and to receive a copy of the comparative nursing care data report as outlined in chapter 118G, section 24 subsection (a). The fee for said report shall be determined by the rate of reasonable copying expenses.

SECTION 5. Chapter 111 of the General Laws is hereby amended by adding the following 9 sections:—

Section 221. As used in sections 221 to 229, inclusive, the following words shall, unless the context clearly requires otherwise, have the following meanings:—

"Adjustment of standards", the adjustment of nurse's patient assignment standards in accordance with patient acuity according to, or in addition to, direct-care registered nurse staffing levels determined by the nurse manager, or his designee, using the patient acuity system developed by the department and any alternative patient acuity system utilized by hospitals, if said system is certified by the department.

"Acuity", the intensity of nursing care required to meet the needs of a patient; higher acuity usually requires longer and more frequent nurse visits and more supplies and equipment.

"Assignment", the provision of care to a particular patient for which a direct-care registered nurse has responsibility within the scope of the nurse's practice, notwithstanding any general or special law to the contrary.

"Assist", patient care that a direct-care registered nurse may provide beyond his patient assignments if the tasks performed are specific and time-limited.

"Board", the board of registration in nursing.

“Circulator”, a direct-care registered nurse devoted to tracking key activities in the operating room.

“Department”, the department of public health.

“Direct-care registered nurse”, a registered nurse who has accepted direct responsibility and

accountability to carry out medical regimens, nursing or other bedside care for patients.

“Facility”, a hospital licensed under section 51, the teaching hospital of the University of Massachusetts medical school, any licensed private or state-owned and state-operated general acute care hospital, an acute psychiatric hospital, an acute care specialty hospital, or any acute care unit within a state-operated facility. As used in sections 221 to 229, inclusive, this definition shall not include rehabilitation facilities or long-term acute care facilities.

“Float nurse”, a direct-care registered nurse that has demonstrated competence in any clinical area that he may be requested to work and is not assigned to a particular unit in a facility.

“Health Care Workforce”, personnel that have an effect upon the delivery of quality care to patients, including but not limited to, licensed practical nurses, unlicensed assistive personnel and/or other service, maintenance, clerical, professional and/or technical workers and other health care workers.

"Mandatory overtime", any employer request with respect to overtime, which, if refused or declined by the employee, may result in an adverse employment consequence to the employee. The term overtime with respect to an employee means any hours that exceed the

predetermined number of hours that the employer and employee have agreed that the employee shall work during the shift or week involved.

"Nurse's patient limit", the maximum number of patients assigned to each direct-care registered nurse at one time on a particular unit.

"Monitor in moderate sedation cases", a direct-care registered nurse devoted to continuously monitoring his patient's vital statistics and other critical symptoms.

"Nurse manager", the registered nurse, or his designee, whose tasks include, but are not limited to, assigning registered nurses to specific patients by evaluating the level of experience, training, and education of the direct-care nurse and the specific acuity levels of the patient.

"Nurse's patient assignment standard", the optimal number of patients to be assigned to each direct-care registered nurse at one time on a particular unit.

"Nursing care", care which falls within the scope of practice as defined in section 80B of chapter 112 or is otherwise encompassed within recognized professional standards of nursing practice, including assessment, nursing diagnosis, planning, intervention, evaluation and patient advocacy.

"Overwhelming patient influx", an unpredictable or unavoidable occurrence at unscheduled or

unpredictable intervals that causes a substantial increase in the number of patients requiring emergent and immediate medical interventions and care, a declared national or state emergency, or the activation of the health care facility disaster diversion plan to protect the public health or safety.

"Patient acuity system", a measurement system that is based on scientific data and compares the registered nurse staffing level in each nursing department or unit against actual patient nursing care requirements of each patient, taking into consideration the health care workforce on duty and available for work appropriate to their level of training or education, in order to predict registered nursing direct-care requirements for individual patients based on the severity of patient illness. Said system shall be both practical and effective in terms of hospital implementation.

"Teaching hospital", a facility as defined in section 51 that meets the teaching facility definition of the American Association of Medical Colleges.

"Temporary nursing service agencies", also known as the nursing pool as defined in section 72Y, and as regulated by the department.

"Unassigned registered nurse", includes, but not limited to, any nurse administrator, nurse supervisor, nurse manager, or charge nurse that maintains his registered nurse licensing certification but is not assigned to a patient for direct care duties.

Section 222. The department shall reevaluate the numbers that comprise the nurse's patient assignment standards and nurse's patient limits and the patient acuity system in the evaluation period and then every 3 years thereafter, taking into consideration evolving technology or changing treatment protocols and care practices and other relevant clinical factors.

Section 223. (a) The department shall develop nurse's patient assignment standards which shall be an ideal number of patients assigned to a direct-care registered nurse that will promote equal, high-quality, and safe patient care at all facilities. The standards shall form the basis of nurse staffing plans set forth in section 225. The department shall use, at a minimum, the

following information to develop nurse's patient assignment standards for all facilities: (1) Massachusetts specific data, including, but not limited to, the role of registered nurses in the commonwealth by type of unit, the current staffing plans of facilities, the relative experience and education of registered nurses, the variability of facilities, and the needs of the

patient population; (2) fluctuating patient acuity levels; (3) variations among facilities and patient care units; (4) scientific data related to patient outcomes, a rigorous analysis of clinical data related to patient outcomes and valid nationally recognized scientific evidence on patient care, facility medical error rates, and health care quality measures; (5) availability of technology; (6) treatment modalities within behavioral health facilities; and (7) public testimony from both the public and experts within the field.

(b) The nurse's patient assignment standards may be adjustable and flexible, as determined by the department, to consider factors, including but not limited to; varying patient acuity, time of day, and registered nurse experience. The number of patients assigned to each direct-care registered nurse may not be averaged. The nurse's patient assignment standards may not refer to a total number of patients and a total number of direct-care registered nurses on a unit and shall not be factored over a period of time.

(c) The department shall develop nurse's patient limits which represent the maximum number of patients to be safely assigned to each direct-care registered nurse at one time on a particular unit. The number of patients assigned to each direct-care registered nurse shall not be averaged and each limit shall pertain to only one direct-care registered nurse. Nurse's patient limits shall not refer to a total number of patients and a total number of direct-care registered nurses on a unit and shall not be factored over a period of time. A facility's failure to adhere to

these nurse's patient limits shall result in non-compliance with this section and the facility shall be subject to the enforcement procedures herein and section 228.

(d) If the commissioner finds that, for any unit, the department cannot arrive at a rationally based limit using available scientific data, the commissioner shall report to: (1) the clerks of the house of representatives and the senate who shall forward the same to the speaker of the house of representatives, the president of the senate , the chairs of the joint committee on public health, and the joint committee on state administration and regulatory oversight; (2) the commissioner of the division of health care financing and policy; and (3) the nursing advisory board as defined in section 16H of chapter 6A, the reasons for the department‘s failure to arrive at a rationally based limit and the data necessary for the department to determine a limit by the next review period.

(e) The setting of nurse's patient assignment standards and nurse's patient limits for registered nurses shall not result in the understaffing or reductions in staffing levels of the health care workforce. The availability of the health care workforce enables registered nurses to focus on the nursing care functions that only registered nurses, by law, are permitted to perform and thereby helps to ensure adequate staffing levels.

(f)Nurse's patient assignment standards and nurse's patient limits shall be determined for the following departments, units or types of nursing care:— intensive care units, (a) critical patient(s) (b) critical unstable patient(s); critical care units, (a) critical patient(s) (b) critical unstable patient(s); neo-natal intensive care (a) critical patient(s) (b) critical unstable patient(s); burn units (a) critical patient(s) (b)critical unstable patient(s); step-down/intermediate care; operating rooms, (a) not to include a registered nurse working as a circulator (b) to be

determined for registered nurse working as a monitor in moderate sedation cases; post anesthesia care with the patient remaining under anesthesia; post-anesthesia care with the patient in a post-anesthesia state; emergency department overall; emergency critical care, provided that the triage, radio or other specialty registered nurse is not included; emergency trauma; labor and delivery with separate standards for (i) a patient in active labor, (ii) patients, or couplets, in immediate postpartum, and (iii) patients, or couplets, in postpartum; intermediate care nurseries; well-baby nurseries; pediatric units; psychiatric units; medical and surgical; telemetry; observational/out-patient treatment; transitional care; acute inpatient rehabilitation; specialty care unit; and any other units or types of care determined necessary by the department.

(g) The department shall jointly, with the department of mental health, develop nurse's patient assignment standards and nurse's patient limits in acute psychiatric care units. These standards and limits shall not interfere with the licensing standards of the department of mental health.

(h) Nothing in this section shall exempt a facility that identifies a unit by a name or term other than those used in this section, from complying with the nurse's patient assignment standards and nurse's patient limits and other provisions established in this section for care specific to the types of units listed.

Section 224. (a) The department shall develop a patient acuity system, as defined in section 221. The department may also certify patient acuity systems developed or utilized by facilities. Patient acuity systems shall include standardized criteria determined by the department. The patient acuity system shall be used by facilities to: (1) assess the acuity of individual patients and assign a value, within a numerical scale, to each individual patient; (2)

establish a methodology for aggregating patient acuity; (3) monitor and address the fluctuating level of acuity of each patient; (4) supplement the nurse's patient assignments and indicate the need for adjustment of direct-care registered nurse staffing as patient acuity changes; and (5) assess the need for health care workforce staff to ensure nurses' focus on the delivery of patient care.

(b) The patient acuity system designed by the department or other patient acuity system used by a facility and certified by the department shall be used in determining adjustments in the number of direct-care registered nurses due to the following factors: (1) the need for specialized equipment and technology; (2) the intensity of nursing interventions required and the complexity of clinical nursing judgment needed to design, implement and evaluate the patient's nursing care plan consistent with professional standards of care; (3) the amount of nursing care needed, both in number of direct-care registered nurses and skill mix of members of the health care workforce necessary to the delivery of quality patient care required on a daily basis for each patient in a nursing department or unit, the proximity of patients, the proximity and

availability of other resources, and facility design; (4) appropriate terms and language that are readily used and understood by direct-care registered nurses; and (5) patient care services provided by registered nurses and the health care workforce.

(c) The patient acuity system shall include a method by which facilities may adjust a nurse's patient assignments within the limits determined by the department as follows: (1) a nurse manager or designee shall adjust the patient assignments according to the patient acuity system whenever practicable as determined by need; (2) a nurse manager or designee shall adjust the patient assignments when the department-developed or certified patient acuity system

indicates a change in acuity of any particular patient to the extent that it triggers an alert mechanism tied to the aggregate patient acuity; (3) a nurse manager or designee shall be responsible for reassigning patients to comply with the patient acuity system, provided that the nurse manager may rearrange patient assignments within the direct-care registered nurses already under management and may also utilize an available float nurse; (4) at any time, any registered nurse may assess the accuracy of the patient acuity system as applied to a patient in the registered nurse's care. Nothing in this section shall supersede or replace any requirements otherwise mandated by law, regulation or collective bargaining contract so long as the facility meets the requirements determined by the department.

Section 225. As a condition of licensing by the department, each facility shall submit annually to the department a prospective staffing plan with a written certification that the staffing plan is sufficient to provide adequate and appropriate delivery of health care services to patients for the ensuing year. A staffing plan shall: (1) incorporate information regarding the number of licensed beds and amount of critical technical equipment associated with each bed in the entire facility; (2) adhere to the nurse's patient assignment standards; (3) employ the department - developed or facility-developed or any alternative patient acuity system developed or utilized by a facility and certified by the department when addressing fluctuations in patient acuity levels that may require adjustments in registered nurse staffing levels as determined by the department; (4) provide for orientation of registered nursing staff to assigned clinical practice areas, including temporary assignments; (5) include other unit or department activity such as discharges, transfers and admissions, and administrative and support tasks that are expected to be

done by direct-care registered nurses in addition to direct nursing care; (6) include written reports of the facility's patient aggregate outcome data; (7) incorporate the assessment criteria used to

validate the acuity system relied upon in the plan; and (8) include services provided by the health care workforce necessary to the delivery of quality patient care. As a condition of licensing, each facility shall submit annually to the department an audit of the preceding year's staffing plan. The audit shall compare the staffing plan with measurements of actual staffing, as well as measurements of actual acuity for all units within the facility assessed through the patient acuity system.

Section 226. (a) A direct-care registered nurse at the beginning of the nurse's shift will be assigned to a certain patient or patients by the nurse manager, who shall use professional judgment in so assigning, provided that the number of patients so assigned shall not exceed the nurse's patient limit associated with the unit.

(b) An unassigned registered nurse may be included in the counting of the nurse to patient assignment standards only when that unassigned registered nurse is providing direct care. When an unassigned registered nurse is engaged in activities other than direct patient care, that nurse shall not be included in the counting of the nurse to patient assignments. Only an unassigned registered nurse, who has demonstrated current competence to the facility to provide the level of care specific to the unit to which the patient is admitted, may relieve a direct-care registered nurse from said unit during breaks, meals, and other routine and expected absences.

(c) Nothing in this section shall prohibit a direct-care registered nurse from assisting with specific tasks within the scope of the nurse's practice for a patient assigned to another nurse.

(d) Each facility shall plan for routine fluctuations in patient census. In the event of an overwhelming patient influx, said facility shall demonstrate that prompt efforts were made to maintain required staffing levels during the influx and that mandated limits were reestablished as

soon as possible, and no longer than a total of 48 hours after termination of the event, unless approved by the department.

(e) For the purposes of complying with the requirements set forth in this section, except in cases of federal or state government declared public emergencies, or a facility-wide emergency, no facility may employ mandatory overtime.

Section 227. (a) No facility shall directly assign any unlicensed personnel to perform non-delegable licensed nurse functions to replace care delivered by a licensed registered nurse. Unlicensed personnel are prohibited from performing functions which require the clinical assessment, judgment and skill of a licensed registered nurse. Such functions shall include, but not be limited to: (1) nursing activities which require nursing assessment and judgment during implementation; (2) physical, psychological, and social assessment which requires nursing judgment, intervention, referral or follow-up; (3) formulation of the plan of nursing care and evaluation of the patient's response to the care provided; (4) administration of medications; and (5) health teaching and health counseling. (b) For purposes of compliance with this section, no registered nurse shall be assigned to a unit or a clinical area within a facility unless the registered nurse has an appropriate orientation in the clinical area sufficient to provide competent nursing care and has demonstrated current competency levels through

accredited institutions and other continuing education providers.

Section 228. (A) If a facility can reasonably demonstrate to the department, with sufficient documentation as determined by the appropriate entity, the attorney general or the division of health care finance and policy, extreme financial hardship as a consequence of

meeting the requirements set forth in sections 221 to 229, inclusive, then the facility may apply to the department for a waiver of up to 9 months.

(B) As a condition of licensing, a facility required to have a staffing plan under this section shall make available daily on each unit the written nurse staffing plan to reflect the nurse's patient assignment standard and the nurse's patient limit as a means of consumer information and protection.

(C) The department shall enforce paragraphs (1) to (6), inclusive, as follows: (1) If the department determines that there is an apparent pattern of failure by a facility to maintain or adhere to nurse's patient limits in accordance with sections 221 to 228, inclusive, the facility may be subject to an inquiry by the department to determine the causes of the apparent pattern. If, after such inquiry, the department determines that an official investigation is appropriate and after issuance of written notification to the facility, the department may conduct an investigation. Upon completion of the investigation and a finding of noncompliance, the department shall give written notification to the facility as to the manner in which the facility failed to comply with sections 221 to 228, inclusive. Facilities shall be granted due process during the investigation, which shall include the following: (a) notice shall be granted to facilities that are noncompliant with sections 221 to 228, inclusive; (b) facilities shall be afforded the opportunity to submit to the department, through written clarification, justifications for failure to comply with sections 221 to 228, inclusive, if so determined by said department, including, but not limited to, patient outcome data and other resources and personnel available to support the registered nurse and patients in the unit, provided however, that facilities shall bear the burden of proof for any and all justifications submitted to the department; (c) based upon such justifications, the department may determine any corrective measures to be taken, if any. Such measures may include: (i) an

official notice of failure to comply; (ii) the imposition of additional reporting and monitoring requirements; (iii) revocation of said facility's license or registration; and (iv) the closing of the particular unit that is noncompliant. (2) Failure to comply with limited nurse staffing requirements shall be evidence of noncompliance with this section. (3) Failure to comply with the provisions of this section is actionable. (4) If the department issues an official notice of failure to comply, as set forth in paragraph (1) of subsection (C) and subclause (i) of clause (c) of said paragraph (1) following submission to and adjudication by the department of justifications for failure to comply submitted by a facility pursuant to clause (b) of paragraph (1) of said subsection (C) to a facility found in noncompliance with limits, the facility shall prominently post its notice within each noncompliant unit. Copies of the notice shall be posted by the facility immediately upon receipt and maintained for 14 consecutive days in conspicuous places including all places where notices to employees are customarily posted. The department shall post the notices on its website immediately after a finding of noncompliance. The notice shall remain on the department’s website for 14 consecutive days or until such noncompliance is rectified, whichever is longer. (5) If a facility is repeatedly found in noncompliance based on a pattern of failure to comply as determined by the department, the commissioner may fine the facility not more than $3,000 for each finding of noncompliance. (6) Any facility may appeal any measure or fine sought to be enforced by the department hereunder to the division of administrative law appeals and any such measure or fine shall not be enforced by the department until final adjudication by the division. (7) The department may promulgate rules and regulations necessary to enforce this section.

Section 229. The department of public health shall provide for (1) an accessible and confidential system to report any failure to comply with requirements of sections 221 to 228,

inclusive, and (2) public access to information regarding reports of inspections, results, deficiencies and corrections under said sections 221 to 228, inclusive, unless such information is restricted by law or regulation. Any person who makes such a report shall identify themselves and substantiate the basis for the report; provided, however, that the identity of said person shall be kept confidential by the department.

SECTION 6. The department of public health shall include in its regulations pertaining to temporary nursing service agencies, or nursing pools, as defined in section 72Y of chapter 111 of the General Laws, and as regulated by the department, parameters in which the department shall deny registration and operation of said agencies only if the agency attempts to increase costs to facilities by at least 10 per cent.

SECTION 7. Section 7 is hereby repealed.

SECTION 8. The department of public health shall submit 2 written reports on its progress in carrying out this act. Said department shall report to the general court the results of its 2 written reports to the clerks of the house of representatives and the senate who shall forward the same to the president of the senate, the speaker of the house of representatives, the chairs of the joint committee on public health. The first report shall be filed on or before March 1, 2012 and the second report shall be filed on or before December 1, 2013.

SECTION 9. The department of public health shall initially evaluate the numbers that comprise the nurse’s patient assignment standards and nurse’s patient limits set forth in sections 221 to 228, inclusive of chapter 111 of the General Laws on or before January 1, 2015.

SECTION 10. The department of public health, shall develop a comprehensive statewide plan to promote the nursing profession in collaboration with: the executive office of housing and

economic development, the board of education, the board of higher education, the board of registration in nursing, the Massachusetts Nurses Association, 1199SEIU, the Massachusetts Hospital Association, Inc., the Massachusetts Organization of Nurse Executives Inc., and any other entity deemed relevant by the department. The plan shall include specific recommendations to increase interest in the nursing profession and increase the supply of registered nurses in the workforce, including recommendations that may be carried out by state agencies. The plan shall be filed with the clerks of the house of representatives and the

senate, who shall forward the same to the president of the senate and the speaker of the house of representatives on or before April 15, 2012.

SECTION 11. Teaching hospitals, as defined in section 221 of chapter 111 of the General Laws, shall meet the applicable requirements of sections 221 to 229, inclusive of said chapter 111 of the General Laws on or before October 1, 2012. All other facilities, as defined in section 221 of chapter 111 of the General Laws, shall meet the applicable requirements of sections 221 to 229, inclusive of said chapter 111 of the General Laws no later than October 1, 2012.

SECTION 12. Section 8 shall take effect on December 1, 2016.

SECTION 13. The department of public health shall, on or before January, 1, 2012, promulgate

regulations defining criteria and proscribing the process for establishing or certifying by the department a standardized patient acuity system, as defined in section 221 of chapter 111 of the General Laws, developed or utilized by a facility as defined in said section 221 of said chapter 111.

SECTION 14. The department of public health shall, on or before March 1, 2012, develop a standardized patient acuity system or certify a facility developed or utilized patient acuity systems, as defined in section 221 of chapter 111 of the General Laws, to be utilized by all facilities to monitor the number of direct-care registered nurses needed to meet patient acuity level.

SECTION 15. The department of public health shall, on or before June 1, 2012, establish, but not before the development or certification of standardized patient acuity systems, nurse's patient assignment standards and nurse's patient limits as defined in section 221 of chapter 111 of the General Laws.

SECTION 16. The department of public health shall, on or before June 1, 2012, promulgate regulations to implement the requirements of section 229 of chapter 111 of the General Laws.

SENATE DOCKET, NO. 1289 FILED ON: 1/20/2011

SENATE . . . . . No. 552

The Commonwealth of Massachusetts

PRESENTED BY:

Karen E. Spilka

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act regarding the all-payer claims database .

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Karen E. Spilka	*Second Middlesex and Norfolk*
Carolyn C. Dykema	*8th Middlesex*
James B. Eldridge	*Middlesex and Worcester*

SENATE . . . . . No. 552

By Ms. Spilka, a petition (accompanied by bill, Senate, No. 552) of Karen E. Spilka, Carolyn C. Dykema and James B. Eldridge for legislation regarding the all-payer claims database. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act regarding the all-payer claims database .

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

SECTION 1. Chapter 6A of the General Laws, as appearing in the 2008 Official Edition, is hereby amended by adding after section 16, the following new section:

16A. The division of health care finance and policy shall be the sole repository for health care data collected pursuant to Section 6 of Chapter 118G. The division shall collect, store and maintain such data in a payer and provider claims database created under said section 6. All other agencies, authorities, councils, boards, and commissions of the commonwealth seeking health care data that is collected under said section 6 shall utilize such data prior to requesting any data from health care providers and payers. The division may enter into interagency services agreements for transfer and use of the data.

SECTION 2. Section 6 of chapter 118G of the General Laws, as amended by chapters 131 and 288 of the acts of 2010, is hereby amended by adding at the beginning thereof the following:

"(a). The division shall establish an all payer and provider health care claims database to record and maintain all information collected by the division under subsection (b). The division shall be the sole administrator and operator of said database and shall be responsible for safeguarding the privacy of information collected, recorded and maintained.

There shall be established a reviewing committee to advise the commissioner on the administration of the data base. The reviewing committee shall be comprised of representatives from the hospital, health plan and provider communities, and shall include, but not be limited to the following: a representative of the Massachusetts Hospital Association, a representative of Blue Cross and Blue Shield of Massachusetts, a representative of the Massachusetts Association of Health Plans, and a representative of the Massachusetts Medical Society. The reviewing committee shall be responsible for advising the division on the standards for release and use of the information submitted and shall ensure that such standards protect patient privacy and guard against utilization of the data for the purpose of anti-competitive behavior.

(b)"

SECTION 3. Said section 6 is hereby further amended by adding at the end thereof the following:

(c) The division shall provide access to information recorded and maintained in the database only in accordance with the division's requirements for protecting patient privacy and shall guard against utilization of the data for the purpose of anti-competitive behavior. Health care providers and payers that supply the data under this section may only be charged reasonable administrative fees for access to information in the database

SENATE DOCKET, NO. 1284 FILED ON: 1/20/2011

SENATE . . . . . No. 555

The Commonwealth of Massachusetts

PRESENTED BY:

Bruce E. Tarr

To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:

The undersigned legislators and/or citizens respectfully petition for the passage of the accompanying bill:

An Act expanding managed care to all Medicaid recipients. .

PETITION OF:

NAME:	DISTRICT/ADDRESS:
Bruce E. Tarr	*First Essex and Middlesex*

SENATE . . . . . No. 555

By Mr. Tarr, a petition (accompanied by bill, Senate, No. 555) of Bruce E. Tarr for legislation to expand managed care to all Medicaid recipients. Health Care Financing.

The Commonwealth of Massachusetts

In the Year Two Thousand Eleven

An Act expanding managed care to all Medicaid recipients. .

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

SECTION 1. Notwithstanding any general or special law to the contrary, the Secretary of Health and Human Services shall move Medicaid members receiving full health insurance benefits into managed care programs.

SECTION 2. This act shall take effect on July 1, 2011.