HOUSE . . . . . No. 4127

Text of an amendment recommended by the committee on Ways and Means to the Senate Bill improving the quality of health care and reducing costs through increased transparency, efficiency and innovation (Senate, No. 2270). May 30, 2012.

The Commonwealth of Massachusetts

In the Year Two Thousand Twelve

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

SECTION 1. Section 38C of chapter 3 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 25, 29, 32, 37, 39, 49, 55 and 86, the words "finance and policy" and inserting in place thereof in each case the following words:— cost and quality

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

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

SECTION 4. Section 16D of chapter 6A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 20 and 21, the words "department of public

health established by section 217 of chapter 111" and inserting in place thereof the following words:— division of health care cost and quality established by section 65 of chapter 118G.

SECTION 5. Sections 16J to 16L, inclusive, of chapter 6Aof the General Laws, as appearing in the 2010 Official Edition, are hereby repealed.

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

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

SECTION 8. Section 16N of said chapter 6A, as so appearing, is hereby amended by striking out, in lines 5 and 6, the words "commissioner of health care finance and policy" and inserting in place thereof the following words:— executive director of the division of health care cost and quality.

SECTION 9. Subsection (a) of section 16O of said chapter 6A, as so appearing, is hereby amended by striking out, in lines 12 through 14, the fifth sentence.

SECTION 10. Section 4R of chapter 7 of the General Laws, as inserted by section 15 of chapter 68 of the acts of 2011, is hereby amended by striking out in the third sentence of subsection (c) the words "finance and policy" and inserting in place thereof the following words:— cost and quality

SECTION 11. Chapter 10 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by adding after section 74 the following section:—

Section 75. (a) There shall be established and set upon the books of the commonwealth a separate fund to be known as the Prevention and Wellness Trust Fund to be expended, without further appropriation, by the department of public health. The fund shall consist of revenues collected by the commonwealth including: (1) any revenue from appropriations or other monies authorized by the general court and specifically designated to be credited to the fund; (2) any fines and penalties allocated to the fund under the General Laws; (3) any gifts, grants and donations to further community-based prevention activities; (4) any interest earned on such revenues; and (5) any funds provided from other sources.

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

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

(c) All expenditures from the Prevention and Wellness Trust Fund shall support the state's efforts to meet the health care cost growth benchmark established in section 46 of chapter 118G and 1 or more of the following purposes: (i) reduce rates of the most prevalent and preventable health conditions, including substance abuse; (ii) increase healthy behaviors; (iii) increase the adoption of workplace-based wellness or health management programs that result in

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

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

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

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

The department of public health shall develop guidelines for an annual review of the progress being made by each grantee. Each grantee shall participate in any evaluation or accountability process implemented or authorized by the department.

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

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

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

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

Public Health Promotion Council and the Centers for Disease Control and Prevention, including, but not limited to, the national prevention strategy, the healthy people report and the community prevention guide.

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

SECTION 12. Chapter 12 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 11L the following section:—

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

The attorney general shall:

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

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

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

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

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

SECTION 14. Section 7A of chapter 26 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting at the end, the following paragraph:—

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

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

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

SECTION 16. Said section 8H of chapter 26, as so appearing, is hereby amended by striking out, in lines 55 and 56, and 77 and 78, the words “uncompensated care pool under section 18” and inserting in place thereof, in each case, the following words:— health safety net trust fund under section 36

SECTION 17. Chapter 29 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 2EEEE the following 2 sections:—

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

(i) making awards to health professionals for repayment assistance for medical or nursing school loans pursuant to section 62 of chapter 118G, provided that in administering the loan forgiveness grant program, a portion of funds therein shall be granted to applicants performing terms of service in rural primary care sites that meet the criteria of a medically underserved area as determined by the health care workforce center;

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

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

(iii) funding residency positions in primary care pursuant to section 64 of chapter 118G; and

(iv) funding rural health rotation programs, rural health clerkships, and rural health preceptorships at medical and nursing schools to expose students to practicing in rural and small town communities.

(b) There shall be credited to the fund all monies payable pursuant to (i) funds that are paid to the health care workforce loan repayment program, established under section 62 of chapter 118G, as a result of a breach of contract and private funds contributed from other sources; and (ii) any revenue from appropriations or other monies authorized by the general court and specifically designated to be credited to the fund, and any gifts, grants, private contributions, investment income earned on the fund's assets and all other sources. Money remaining in the fund at the end of a fiscal year shall not revert to the General Fund.

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

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

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

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

The division, in consultation with the Massachusetts Hospital Association, shall develop a competitive grant process for awards to be distributed to distressed hospitals out of said fund. The grant process consideration shall include, but not be limited to, the following factors: (1) payer mix, (2) financial health and its financial needs in the context of being viable in the long term, (3) geographic need, and (4) population need. In assessing financial health, the division shall take into account day's cash on hand, net working capital, earnings before depreciation and amortization, and access to working capital.

SECTION 18. Section 1 of chapter 32 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after the word "connector", in line 216, the following words:— , the division of health care cost and quality established under section 2 of chapter 118G

SECTION 19. Section 2 of chapter 32A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after the word “authority” the following words:— , the division of health care cost and quality established under section 2 of chapter 118G

SECTION 20. Said chapter 32A of the General Laws, as so appearing, is hereby amended by inserting after section 26 the following 3 sections:-

Section 27. Pursuant to section 50 of chapter 118G, not later than January 1, 2014 the commission shall provide a toll-free number and website that enables consumers to request and obtain from the commission in real time the maximum estimated amount the employee shall be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the commission at the time the request is made, including any copayment, deductible, coinsurance or other out of pocket amount for any health care benefits; and a consumer disclosure alerting the employee that these are estimated costs, and that the actual amount the employee will be responsible to pay for a proposed admission, procedure or service may vary.

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

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

SECTION 21. Chapter 32B of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 29 the following 3 sections:-

Section 30. Pursuant to section 50 of chapter 118G, not later than January 1, 2014, every appropriate public authority which has accepted this chapter shall provide a toll-free number and website that enables consumers to request and obtain from the public authority in real time the maximum estimated amount the subscriber shall be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the public authority at the time the request is made, including any copayment, deductible, coinsurance or other out of pocket amount for any health care benefits, and a consumer disclosure alerting the subscriber that these are estimated costs, and that the actual amount the subscriber will be responsible to pay for a proposed admission, procedure or service may vary.

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

Section 32. Pursuant to section 50 of chapter 118G, every appropriate public authority which has accepted this chapter shall disclose patient-level data including, but not limited to, health care service utilization, medical expenses, demographics, and where services are being provided, to all providers in their network, provided that data shall be limited to patients treated by that provider, so as to aid providers in managing the care of their own patient panel.

SECTION 22. Sections 6D to 6G of chapter 40J of the General Laws, as appearing in the 2010 Official Edition, are hereby repealed.

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

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

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

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

SECTION 25. Section 1 of chapter 62D of the General Laws, as amended by section 13 of chapter 142 of the acts of 2011, is hereby amended by striking out, in lines 9 and 10, the words "finance and policy in the exercise of its duty to administer the uncompensated care pool" and inserting in place thereof the following words:— cost and quality in the exercise of its duty to administer the Health Safety Net Trust Fund.

SECTION 26. Said section 1 of chapter 62D, as so appearing, is hereby further amended by striking out, in lines 30 through 35, the words "finance and policy on behalf of the uncompensated care pool by a person or a guarantor of a person who received free care services paid for in whole or in part by the uncompensated care pool or on whose behalf the

uncompensated care pool paid for emergency bad debt, pursuant to subsection (m) of section 18 of chapter 118G" and inserting in place thereof the following words:— cost and quality, through the health safety net office, on behalf of the Health Safety Net Trust Fund by a person or a guarantor of a person who received free care services paid for in whole or in part by the Health Safety Net Trust Fund

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

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

SECTION 29. Section 10 of said chapter 62D, as so appearing, is hereby amended by striking out, in lines 8 and 9, the words "the division of medical assistance, the corporation, the office of the state comptroller, and the division of health care finance and policy" and inserting in place thereof the following words:— the office of Medicaid, the corporation, the office of the state comptroller, and the division of health care cost and quality

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

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

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

SECTION 33. Chapter 63 of the General Laws, as amended by section 70 of chapter 68 of the acts of 2011, , is hereby amended by inserting after section 38CC the following section:—

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

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

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

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

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

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

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

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

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

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

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

SECTION 42. Section 25B of said chapter 111, as so appearing, is hereby further amended by striking out, in line 54, the words “mentally ill or retarded” and inserting in place thereof the following words:- developmentally disabled or mentally ill.

SECTION 43. Section 25B of chapter said 111, as so appearing, is hereby further amended by inserting after the word “basis”, in line 85, the following words:- whether provided in a free standing ambulatory surgical center licensed as a clinic pursuant to section 51 or by a hospital.

SECTION 44. Section 25B of said chapter 111, as so appearing, is hereby further amended by striking out the definition “Innovative service” and inserting in place thereof the following definition:-

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

SECTION 45. Section 25B of said chapter 111, as so appearing, is hereby further amended by striking out the definition “New technology” and inserting in place thereof the following definition:-

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

SECTION 46. Section 25B of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 120 to121, the words “A new technology or innovate” and inserting in place thereof the following words:- a new technology or innovative

SECTION 47. Section 25B of said chapter 111, as so appearing, is hereby further amended by inserting after the word "(b)", in line 122, the following words:- for any acute hospital, any increase in bed capacity of more than 4 beds, (c)

SECTION 48. Section 25B of said chapter 111, as so appearing, is hereby further amended by striking out, in lines 150 to154, the last sentence of the definition of "Substantial change in services" and inserting in place thereof the following sentence:- Notwithstanding any other provisions to the contrary, the department may further define what constitutes a substantial change in service in regulations, including, but not limited to, any changes in its provision of ambulatory surgery services by any facility that provides ambulatory surgery.

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

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

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

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

SECTION 53. Section 25C of said chapter 111, as so appearing, is hereby further amended by striking out the fourth paragraph and inserting in place thereof the following paragraph:- No person or agency of the commonwealth or any political subdivision thereof shall acquire for location in other than a health care facility a unit of medical, diagnostic, or therapeutic equipment, other than equipment used to provide an innovative service or which is a new technology, as such terms are defined in section 25B, with a fair market value in excess of $250,000 unless the person or agency notifies the department of the person’s or agency’s intent to acquire such equipment and of the use that will be made of the equipment, provided however maintenance or replacement of existing equipment defined as new technology shall not require a review. Such notice shall be made in writing and shall be received by the department at least 30 days before contractual arrangements are entered into to acquire the equipment with respect to which notice is given. A determination by the department of need therefor shall be required for any such acquisition (i) if the notice required by this paragraph is not filed in accordance with the requirements of this paragraph, and (ii) if the requirements for exemption under subsection (a) of section 25C1/2; provided, however, that in no event shall any person who acquires a unit of new technology for location other than in a health care facility refer or influence any referrals of patients to said equipment, unless said person is a physician directly providing services with that equipment; provided, however, that for the purposes of this section, no public advertisement shall be deemed a referral or an influence of referrals; and provided, further, that any person who

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

SECTION 54. Section 25C of said chapter 111, as so appearing, is hereby further amended by striking out paragraphs 5 through 7, inclusive, and inserting in place thereof the following 3 paragraphs:—

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

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

care personnel, (2) are unlikely to result in any increase in the clinical bed capacity or outpatient load capacity of the facility, and (3) are unlikely to cause an increase in the total patient care charges of the facility to the public for health care services, supplies, and accommodations, as such charges shall be defined from time to time in accordance with section 5 of chapter 409 of the acts of 1976. Any determination of need shall be guided by the state health plan.

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

SECTION 55. Said chapter 111, as so appearing, is hereby further amended by inserting after section 25E the following section:—

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

(b) There shall be in the department a health planning council consisting of the commissioner or a designee, the director of the office of Medicaid or a designee, the executive director of the division of health care cost and quality or a designee, the secretary of health and human services or a designee, the director of the division, and 3 members appointed by the governor, of whom at

least 1 shall be a health economist; at least 1 shall have experience in health policy and planning, and at least 1 shall have experience in health care market planning and service line analysis. The health planning council shall advise the division and shall oversee and issue the state health plan developed by the division.

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

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

SECTION 56. Section 25G of said chapter 111, as so appearing, is hereby amended by inserting at the end thereof the following sentence:—

Any violation of such provisions also shall constitute grounds to refuse to accept, review or consider an application for a determination of need by the facility, its affiliates, including a parent, subsidiary, umbrella organization or another facility in the same health system or organization, or grounds for additional terms and conditions on any subsequent application for a determination of need by the facility or its affiliates, including a parent, subsidiary, umbrella organization or another facility in the same health system or organization for a minimum of 5 years.

SECTION 57. Sections 25L to 25N, inclusive, of chapter 111 of the General Laws, as so appearing, are hereby repealed.

SECTION 58. Section 25P of chapter 111 of the General Laws, as so appearing, is hereby repealed.

SECTION 59. Section 51 of chapter 111 of the General Laws, as so appearing, is hereby amended by striking out, in lines 36 and 46, the words “finance and policy” and inserting, in each instance, in place thereof the following words:— cost and quality

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

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

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

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

SECTION 64. Section 51G of said chapter 111, as so appearing, is hereby further amended by inserting after paragraph (6) the following paragraph:- (7) Any violation of the requirements under this section also shall constitute grounds for refusing to grant or renew, modifying or revoking the license of a health care facility or of any part thereof, grounds to refuse to accept, review or consider an application for a determination of need by the facility, its affiliates, including a parent, subsidiary, umbrella organization or another facility in the same health system or organization, or grounds for additional terms and conditions on any subsequent application for a determination of need by the facility or its affiliates, including a parent, subsidiary, umbrella organization or another facility in the same health system or organization for a minimum of 5 years.

SECTION 65. Section 51H of said chapter 111 of the General Laws, as so appearing, is hereby amended by striking out subsection (c) and inserting in place thereof the following subsection:—

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

SECTION 66. Chapter 111 of the General Laws, as so appearing, is hereby amended by inserting after section 51H the following new section:-

Section 51I. (a) As used in this section, the following word shall have the following meaning: --

"Facility", any hospital, as defined in section 52, or clinic conducted by a hospital, as licensed under section 51, which receives a separate on-site review survey by the Joint Commission on the Accreditation of Healthcare Organizations.

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

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

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

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

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

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

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

(i) A facility shall be exempt from the requirements of this section if the facility (1) has entered into at least 1 alternative payment methodology contract, and (2) receives payment through an alternative payment methodology for at least 50 per cent of the patients receiving primary care services.

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

SECTION 67. Said chapter 111 of the General Laws, as so appearing, is hereby amended by inserting after section 53G the following section:—

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

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

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

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

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

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

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

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

(c) A physician organization shall be defined as a group of physicians contracting as a single entity rather than in their individual capacities unless the group consists of 9 physicians or fewer; provided however, that any licensed entity including, but not limited to, hospitals and clinics that directly employ physicians shall not be required to register as a physician organizations.

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

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

(f) Any physician organization whose application has been rejected or denied, or who has been issued a certificate with conditions or at a lower level than applied for, may request an adjudicatory hearing pursuant to chapter 30A within 21 days of the division's decision. The division shall notify the attorney general and the division of insurance upon receipt of such hearing request. Said hearing shall be conducted within 30 days of the division's receipt of the hearing request. The attorney general may intervene in a hearing under this subsection and may

require the production of additional information or testimony. The commissioner shall issue a written decision within 30 days of the conclusion of the hearing.

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

SECTION 68. Section 62M of chapter 111 of the General Laws, as so appearing, is hereby amended by striking out, in line 13, the words "finance and policy" and inserting in place thereof the following words:— cost and quality

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

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

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

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

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

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

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

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

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

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

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

SECTION 80. Chapter 111 of the General Laws, as so appearing, is hereby amended by inserting after section 206 the following section:-

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

SECTION 81. Section 217 of said chapter 111 of the General Laws, as so appearing, is hereby repealed

SECTION 82. Said chapter 111 of the General Laws, as so appearing, is hereby amended by inserting after section 224 the following 2 sections:—

Section 225. (a) Effective July 1, 2013, upon request by a patient or prospective patient, a health care provider shall disclose the charges, and if available, the allowed amount, or where it is not possible to quote a specific amount in advance due to the health care provider's inability to predict the specific treatment or diagnostic code, the estimated charges or estimated allowed amount for a proposed admission, procedure or service.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 84. Section 2 of chapter 112 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting the following after the second sentence of the first paragraph:—The board shall require, as a standard of eligibility for licensure, that applicants demonstrate proficiency in the use of computerized physician order entry, e-prescribing, electronic health records and other forms of health information technology, as determined by the board. As used in this section, proficiency, at a minimum shall mean that applicants demonstrate the skills to comply with the "meaningful use" requirements, so-called, as set forth in 45 C.F.R. Part 170.

SECTION 85. Said chapter 112 of the General Laws, as so appearing, is hereby amended by inserting after section 2C, the following section:—

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

SECTION 86. Section 9C of chapter 112 of the General Laws, as so appearing, is hereby amended by striking the definition of "physician assistant" and inserting in place thereof the following definition:-

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

SECTION 87. Section 9E of chapter 112 of the General Laws, as so appearing, is hereby amended by striking out, in lines 5 and 6, the words "A registered physician shall supervise no more than 4 physician assistants at any one time."

SECTION 88. Said section 9E of chapter 112 of the General Laws, as so appearing, is hereby amended by striking out, in lines 15 through 17, the words "Any prescription of medication made by a physician assistant must include the name of the supervising physician."

SECTION 89. Chapter 112 of the General Laws, as so appearing, is hereby amended by inserting after section 80H the following section:—

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 or mental health, that requirement may be fulfilled by a nurse practitioner practicing under section 80B. Nothing in this section shall be construed to expand the scope of practice of nurse practitioners. This section shall not be construed to preclude the development of mutually agreed upon guidelines between the nurse practitioner and supervising physician under section 80E of chapter 112.

SECTION 90. Chapter 118E of the General Laws is hereby amended by inserting after section 9E the following section:-

Section 9F. (a) As used in this section, the follow words shall have the following meanings:-

"Dual eligible", or "dually eligible person", any person age 21 or older and under age 65 who is enrolled in both Medicare and either MassHealth or CommonHealth; provided that the executive office may include within the definition of dual eligible any person enrolled in MassHealth or CommonHealth who also receives benefits under Title II of the Social Security Act on the basis of disability and will be eligible for Medicare within 24 months, provided that the executive office may limit eligibility to those who will be eligible for Medicare within a prescribed number of months that is less than 24.

"Integrated care organization" or "ICO", a comprehensive network of medical, health care and long term services and supports providers that integrates all components of care, either directly or through subcontracts and has been contracted with by the executive office of health and human services and designated an ICO to provide services to dually eligible individuals pursuant to this section.

(b) Members of the MassHealth dual eligible pilot program on ICOs or any successor program integrating care for dual eligible persons shall initially be provided an independent community care coordinator by the ICO or successor organization, who shall be a participant in the member's care team. The member may direct the withdrawal or reinstatement of the independent care coordinator at any time. The community care coordinator shall assist in the development of a long term support and services care plan. The community care coordinator shall:

(1) participate in initial and ongoing assessments of the health and functional status of the member, including determining appropriateness for long term care support and services, either in the form of institutional or community-based care plans and related service packages necessary to improve or maintain enrollee health and functional status;

(2) arrange and, with the agreement of the care team, coordinate and authorize the provision of appropriate institutional and community long term care and supports and services, including assistance with the activities of daily living and instrumental activities of daily living, housing, home-delivered meals, transportation, and under specific conditions or circumstances established by the ICO or successor organization, authorize a range and amount of community-based services; and

(3) monitor the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the care team; and

track member satisfaction and the appropriate provision and functional outcomes of community long term care services, according to the service plan as deemed appropriate by the care team.

(c) The ICO or successor organization shall not have a direct or indirect financial ownership interest in an entity that serves as an independent care coordinator. Providers of institutional or community based long term services and supports on a compensated basis shall not function as an independent care coordinator, provided however that the secretary may grant a waiver of this restriction upon a finding that public necessity and convenience require such a waiver. In the case of a member in the program age 60 or older, the member shall be offered the option of the services of an independent care coordinator as designated by the executive office of elder affairs pursuant to the provisions of section 4B of chapter 19 A. For purposes of this section, an organization compensated to provide only evaluation, assessment, coordination and fiscal intermediary services shall not be considered a provider of long term services and supports.

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

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

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

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

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

SECTION 96. Chapter 118E of the General Laws, as so appearing, is hereby amended by adding the following 8 sections:—

Section 63. In connection with the governor’s fiscal year 2015 budget recommendation, the secretary of administration and finance and the director of Medicaid shall submit to the legislature a plan to ensure greater predictability and stability in the rates paid by Medicaid to

health care providers. The plan shall include the establishment of a Medicaid reserve fund or a similar mechanism.

Section 63A. The office of Medicaid shall establish rates paid to providers at least 60 days prior to the time such rates take effect.

Section 64. As of July 1, 2013, rates paid by Medicaid to acute care hospitals and to providers of primary care services shall provide an additional 2 per cent bonus above other adjustments to the annual rate calculations, including updates for inflation, case-mix adjustments, base year updates, and any other improvements to the rate methodology;provided, however, that only those hospitals and providers that have demonstrated to the satisfaction of the division of health care cost and quality a significant transition to the use of alternative payment methodologies shall be eligible for the 2 per cent bonus payment. The division of health care cost and quality shall establish by regulation what constitutes a significant use of alternative payment methodologies by a provider. The office of Medicaid shall not offset the 2 per cent bonus by reducing Medicaid base rates to acute hospitals or providers of primary care.

Section 65. The office of Medicaid shall develop an accountable care organization and patient-centered medical home innovation project that employs alternative payment methodologies including, but not limited to, bundled payments, global payments, shared savings and other innovative methods of paying for health care services. The office of Medicaid shall take actions necessary to amend its managed care organization and primary care clinician contracts as necessary to include such contracts in the innovation project. In developing the innovation project that employes alternative payment methodologies, the office of Medicaid shall ensure payment and quality metric alignment with existing accountable care demonstrations

implemented by the Centers for Medicare and Medicaid Services. The office of Medicaid shall consult with stakeholders including, but not limited to, the division of health care cost and quality, hospitals or hospital associations, carriers or carrier associations, consumer groups, physician or physician associations, and other health care providers on such projects and alternative payment methodologies under this section.

Section 66. To the greatest extent possible, the office of Medicaid shall pay for health care using the accountable care organization or patient-centered medical home model of delivering health care services.

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

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

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

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

Section 67. To the extent that the office of Medicaid continues to pay acute care hospitals and other providers on a fee-for-service basis, the office shall establish, in cases in which the office believes it would enhance the health care quality and assist in achieving the state wide health care cost growth targets under section 46 of chapter 118G, a shared savings payment program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"Bundled payment for acute care episode," a single payment arrangement that pays for all the services, including, but not limited to, phyisician, professional and hospital services, associated with a clinically defined episode of care.

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

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

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

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

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

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

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

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

"Division", the division of health care cost and quality established by section 2.

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

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

"Emergency bad debt", bad debt related to emergency services provided by an acute hospital to an uninsured individual.

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

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

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

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

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

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

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

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

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

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

“Free care”, the following medically necessary services provided to individuals determined to be financially unable to pay for their care, in whole or in part, pursuant to applicable regulations of the division: (1) services provided by acute hospitals; (2) services provided by community health centers; and (3) patients in situations of medical hardship in which major expenditures for health

care have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services cannot be paid, as determined by regulations of the division.

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

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

"Governmental mandate", a state or federal statutory requirement, administrative rule, regulation, assessment, executive order, judicial order or other governmental requirement that directly or indirectly imposes an obligation and associated compliance cost upon a provider to

take an action or to refrain from taking an action in order to fulfill the provider's contractual duty to a procuring governmental unit.

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

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

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

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

"Growth rate of potential gross state product", the long-run average growth rate of the commonwealth's economy, ignoring fluctuations due to the business cycle.

"Health benefit plan", as defined in section 1 of chapter 176J.

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

"Health care services", supplies, care and services of medical, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital care and services; services provided by a community health center or by a sanatorium, as

included in the definition of “hospital” in Title XVIII of the federal Social Security Act, and treatment and care compatible with such services or by a health maintenance organization.

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

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

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

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

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

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

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

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

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

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

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

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

"Medical spend", the total cost of care for the patient population associated with a provider group, based on allowed claims for all catagories of medical expenses and all non-claims related payments to providers during a calendar year.

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

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

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

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

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

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

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

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

"Patient-centered medical home", a model of health care delivery designed to provide a patient with a single point of coordination for all their health care, including primary, specialty, post-

acute and chronic care, which is (a) patient-centered; (b) comprehensive, integrated and continuous; and (c) delivered by a team of health care professionals to manage a patient's care, reduce fragmentation, and improve patient outcomes.

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

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

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

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

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

"Performance penalty", a reduction in the payments made by a payer to a provider for failing to achieve certain quality measures as herein defined. Performance penalties and their

implementation shall comply with this chapter, any regulations of the division, and the contract between a provider and a payer.

"Physician", a medical or osteopathic doctor licensed to practice medicine in the commonwealth.

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

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

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

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

"Physician organizations", shall mean a physician organization certified under section 53H of chapter 111.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

"State-funded employee", any employed person, or dependent of such person, who receives, on more than 3 occasions during any hospital fiscal year, health services paid for as free care; or any employed persons, or dependents of such persons, of a company that has 5 or more occurrences

of health services paid for as free care by all employees in aggregate during any fiscal year. An occurrence shall include all healthcare related services incurred during a single visit to a health care professional.

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

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

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

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

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

SECTION 98. Chapter 118G of the General Laws is hereby amended by striking out section 2, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:—

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

(b) There shall be a board, with duties and powers established by this chapter, which shall govern the division. The board shall consist of 9 members: the secretary of administration and finance, ex officio; the secretary of health and human services, ex officio; 4 members appointed by the governor, 1 of whom shall be a health care economist, 1 of whom shall be an expert in hospital administration and finance, 1 of whom shall be an expert in the development and utilization of innovative medical technologies and treatments for patient care, and 1 of whom shall be a primary care provider licensed to practice in the commonwealth; and 3 members appointed by the attorney general, 1 of whom shall be a practicing nurse licensed to practice in the commonwealth, 1 of whom shall be an expert in health care administration and finance, and 1 of whom shall be an expert in a health care consumer advocacy and privacy protection. The governor shall designate the chairperson of the board. All appointments shall serve a term of 3 years, but a person appointed to fill a vacancy shall serve only for the unexpired term. An appointed member of the board shall be eligible for reappointment. The board shall annually elect 1 of its members to serve as vice-chairperson. Each member of the board serving ex officio may appoint a designee under section 6A of chapter 30.

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

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

(e) The chairperson shall appoint an executive director. The executive director shall supervise the administrative affairs and general management and operations of the division and also serve as secretary of the division, ex officio. The executive director shall receive a salary commensurate with the duties of the office. The executive director may appoint other officers and employees of the division necessary to the functioning of the division. Sections 9A, 45, 46, and 46C of chapter 30, chapter 31 and chapter 150E shall not apply to the executive director or any other employees of the division. The executive director shall, with the approval of the board:

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

(ii) employ professional and clerical staff as necessary;

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

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

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

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

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

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. Such regulations shall be adopted, after notice and hearing, only upon consultation with representatives of nonprofit hospital service corporations established under chapter 176A, elected representatives of health systems agencies designated pursuant to Title XV of the federal public health service act, representatives of companies authorized to sell accident and health insurance under chapter 175 and the Massachusetts Hospital Association.

SECTION 99. Section 2A of chapter 118G of the General Laws, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:—

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

SECTION 100. Chapter 118G of the General Laws is hereby further amended by striking out section 3, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

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

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

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

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

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

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

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

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

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

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

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

SECTION 101. Chapter 118G of the General Laws, as so appearing, is hereby amended by inserting after section 3 the following 2 sections:—

Section 3A. (a) The division shall work with other state agencies including, but not limited to, the department of public health, the department of mental health, the division of medical assistance and the division of insurance to collect and publish data concerning the cost of health insurance in the commonwealth and the health status of individuals, hold annual hearings concerning health care provider and payer costs and cost trends, and to provide an analysis of health care spending trends with recommendations for strategies to promote an efficient health delivery system. The division shall make available actual costs of health care services, as supplied by each provider, to the general public in the manner specified in section 59.

(b) The division shall have the power to design and to revise, consistent with this chapter, a basic schedule of health care services that enrollees in any health insurance program implemented by the division shall be eligible to receive. Such covered services shall include those which typically are included in employer-sponsored health benefit plans in the commonwealth. The division may promulgate schedules of covered health care services which differ from the basic schedule and which apply to specific classes of enrollees. The division may promulgate a schedule of premium contributions, co-payments, co-insurance, and deductibles for said programs, including reduced premiums based on a sliding fee, and other fees and revise them from time to time, subject to the approval of the division of insurance; and provided, however, that such schedule shall provide for such enrollees to pay 100 per cent of such premium contributions if their income substantially exceeds the non-farm poverty guidelines of the United States office of management and budget.

(c) 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. Such regulations shall be adopted, after notice and hearing, only upon consultation with representatives of nonprofit hospital service corporations established under chapter 176A, elected representatives of health systems agencies designated pursuant to Title XV of the federal public health service act, representatives of companies authorized to sell accident and health insurance under chapter 175 and the Massachusetts Hospital Association.

Section 3B. The division shall implement the reform of the health care delivery and payment system in the commonwealth in accordance with this chapter. The board shall (i) monitor the establishment of ACOs; (ii) monitor the development of patient-centered medical homes; (iii) monitor the adoption of alternative payment methodologies and health care delivery systems by

providers; and (iv) ensure the consistent and effective use by providers of quality measures to promote patient-centered, timely, high-quality and safe care for individuals in the commonwealth.

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

SECTION 103. Section 5 of chapter 118G of the General Laws, as so appearing, is hereby repealed.

SECTION 104. Section 6 of chapter 118G of the General Laws, as so appearing, is hereby amended by striking out the first sentence and inserting in place thereof the following sentence:—

The division may promulgate such regulations as necessary to ensure the uniform reporting of revenues, charges, costs, and utilization of health care services and other such data as the division may require of institutional providers and their parent organizations and any other affiliated entities, non-institutional providers including, but not limited to, physician group and physician organization entities, and ACOs; provided that physicians in contracting units of not more than 9 physicians shall be exempt from said reporting.

SECTION 105. Section 6 of chapter 118G of the General Laws, as so appearing, is hereby further amended by inserting after the words “provider group,”, in line 52 and 75 and 76,the following words:— , accountable care organization, as defined in chapter 118J, physician organization, as defined in section 53H of chapter 111,

SECTION 106. Section 6 of chapter 118G of the General Laws, as so appearing, is hereby further amended by inserting after the word “hospital”, in lines 54 and 77, the following words:—

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

SECTION 107. Said section 6½ of chapter 118G of the General Laws, as so appearing, is hereby further amended by striking out, in lines 50 and 51, the words “and (x) any witness identified by the attorney general” and inserting in place thereof the following:—

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

SECTION 108. Section 6 ½ of chapter 118G of the General Laws, as so appearing, is hereby amended by inserting after the word “technology”, in line 62, the following words:—and the impact of price transparency on prices

SECTION 109. Said section 6½ of chapter 118G of the General Laws, as so appearing, is hereby further amended by inserting, in line 69, after the word “practices” the following words:— the impact of price transparency on prices,

SECTION 110. Section 6½ of chapter 118G of the General Laws, as so appearing, is hereby further amended by striking out, in lines 78 through 80, the third sentence of subsection (g).

SECTION 111. Said section 6½ of chapter 118G of the General Laws, as so appearing, is hereby further amended by adding at the end thereof the following paragraph:—

As used in this section, "provider," shall mean any person, corporation partnership, governmental unit, state institution, accountable care organization, physician organization, hospital system, or any other entity qualified under the laws of the commonwealth to perform or provide health care services. Physicians in contracting units of not more than 9 physicians shall not be subject to this section.

SECTION 112. Chapter 118G of the General Laws is hereby amended by striking out section 6A, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

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

(b) The division shall publish annual reports and establish a continuing program of investigation and study of financial trends in the acute hospital industry, including an analysis of systemic instabilities or inefficiencies that contribute to financial distress in the acute hospital industry.

Such reports shall include an identification and examination of hospitals that the division considers to be in financial distress, including any hospitals at risk of closing or discontinuing essential health services, as defined by the department of public health pursuant to section 51G of chapter 111, as a result of financial distress.

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

SECTION 113. Section 7 of chapter 118G of the General Laws, as so appearing, is hereby amended by inserting after the words “executive office”, in line 1, the following words:— , in consultation with the division,

SECTION 114. Section 11 of chapter 118G of the General Laws, as so appearing, is hereby amended by striking out, in line 45, the words “finance and policy” and inserting in place thereof the following words:—c ost and quality

SECTION 115. Section 11 of chapter 118G of the General Laws, as so appearing, 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 require Medicaid, any carrier or other entity which contracts with the office of Medicaid to pay for or arrange for the purchase of health care services, the commonwealth care health insurance program established under chapter 118H, any carrier or other entity which contracts with the commonwealth care health insurance program to pay for or arrange for the purchase of health care services, the group insurance commission established under chapter 32A, and any other state sponsored or state managed plan providing health care benefits to reimburse

any licensed hospital facility operating in the commonwealth that has been designated as a critical access hospital pursuant to U.S.C. 1395i-4, in an amount equal to at least 101 per cent of allowable costs under each such program, as determined by utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services provided to eligible patients of such facility.

SECTION 116. Section 18B of chapter 118G of the General Laws, as so appearing, is hereby repealed.

SECTION 117. Section 24 of chapter 118G of the General Laws, as so appearing, is hereby amended by striking out, in line 7, the words "department of public health" and inserting in place thereof the following words:— division

SECTION 118. Section 34 of chapter 118G of the General Laws, as so appearing, is hereby amended by striking out, in line 29, the words "finance and policy" and inserting in place thereof the following words:— cost and quality

SECTION 119. Section 35 of chapter 118G of the General Laws, as so appearing, is hereby amended by striking out, in line 76, the words "finance and policy" and inserting in place thereof the following words:— cost and quality

SECTION 120. Chapter 118G of the General Laws is hereby amended by striking out section 40, as appearing in the 2010 Official Edition, and inserting in place thereof the following section:-

Section 40. (a) Acute hospitals and ambulatory surgical centers shall be assessed a one-time surcharge to be paid to the division for the distressed hospital trust fund, created under section

2GGGG of chapter 29 to be paid by July 1, 2013. The surcharge amount shall equal the product of (i) the surcharge percentage and (ii) the assessment. The division shall calculate the surcharge percentage by dividing the acute hospital's patient service revenue by the total patient service revenues of acute hospitals paying an assessment under this section. The assessment shall equal the product of (i) the statewide medical spend in calendar year 2011 and (ii) 0.2 per cent. The division shall determine the surcharge percentage for the one-time assessment by December 31, 2012. In the determination of the surcharge percentage, the division shall use the best data available as determined by the division and may consider the effect on projected surcharge payments of any modified or waived enforcement pursuant to subsection (g). 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. The division may waive the assessment for an acute hospital or ambulatory surgical center, if it finds the hospital or ambulatory surgical center is unable to pay the assessment; provided that if an acute hospital or ambulatory surgical is a part of a system, then the system as a whole shall be financially reviewed. The division shall make a determination for waiver based on the following factors: (A) cash and investments on hand, (B) total revenues, (C) total case and investments, (D) total reserves,(E) total profits, margins or surplus, (F) earnings before interest, depreciation and amortization, (G) administrative expense ratio, and (H) the compensation of executive managers and board members;provided however, any hospital system with less than $1,000,000,000 in total net assets and more than 50 per cent of revenues from public payers shall be exempt from this section.

(b) Surcharge payors shall be assessed a one-time surcharge to be paid to the division for the distressed hospital trust fund, created under section 2GGGG of chapter 29 by July 1, 2013. The

surcharge amount shall equal the product of (i) the surcharge percentage and (ii) the assessment. The division shall calculate the surcharge percentage by dividing the surcharge payor's payments for acute hospital services by the payment for acute hospital services by all surcharge payors. The assessment shall equal the product of (i) the statewide medical spend in calendar year 2011 and (ii) 0.2 per cent. The division shall determine the surcharge percentage for the one-time assessment by December 31, 2012. In the determination of the surcharge percentage, the division shall use the best data available as determined by the division and may consider the effect on projected surcharge payments of any modified or waived enforcement pursuant to subsection (g). 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. The division may waive the assessment for a payor, if it finds the payor is unable to pay. The division shall take into account the following factors when determining if a payor is able to pay: (A) total revenues, (B) total premium receipts, (C) total reserves, (D) total profits, margins or surplus, (E) medical loss ratio and administrative expense ratio, and (F) the compensation of the executive managers and board members.

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

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

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

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

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

proper notice that the division intends to initiate enforcement actions under regulations promulgated by the division.

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

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

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

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

SECTION 121. Chapter 118G of the General Laws, as so appearing, is hereby further amended by inserting after section 41 the following 29 sections:—

Section 42. The division shall:

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

(b) encourage the establishment of alternative payment methodologies, ACOs and patient centered medical homes and to ensure consistency and efficacy in the establishment and use of

quality measures throughout the commonwealth to promote patient-centered, timely, safe, high quality care for individuals in the commonwealth;

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

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

Section 43. (a) Commencing no later than January 1, 2014, the group insurance commission, the commonwealth health insurance connector authority, the office of Medicaid and any other state funded insurance program shall implement alternative payment methodologies for their respective covered lives and programs thereunder.

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

(c) Commencing no later than January 1, 2015, private health plans shall implement alternative payment methodologies. Private health plans may seek a waiver from the division in order to use

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

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

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

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

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

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

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

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

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

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

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

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

(f) For continued certification by the division under this section, the division may establish and monitor specific quality standards. Such quality standards shall be developed with reference to the standard quality measure set established by section 68 of chapter 118G.

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

(h) The division shall develop a standard payment system for patient-centered medical homes certified under this section or recognized by the National Committee for Quality Assurance as a patient-centered medical home. In developing the standard payment system, the division shall consider, but not be limited to, per-patient payments, payment levels based on care-complexity, and payments for care coordination, clinical management, quality performance and shared

savings. Development of the standard patient-centered medical home payment system shall be completed by January 1, 2014.

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

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

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

Section 46. (a) The division shall calculate a statewide medical spend benchmark by July 1. The benchmark shall be calculated by multiplying (1) the statewide medical spend benchmark of the prior year; and (2) the modified potential gross state product growth rate, as determined in subsection (b).

For the initial statewide medical spend benchmark in 2012, the division shall calculate the medical spend for 2011 and multiply that number by the modified potential state product growth rate for calendar year 2012.

(b) (1) As part of the governor's annual budget submission, the secretary for administration and finance shall publish the potential gross state product growth rate for the following calendar year beginning on January 1. Notwithstanding this subsection, for calendar years 2012 and 2013 the potential gross state product growth rate shall be 3.6%.

(2) The division shall calculate the modified potential gross state product growth rate by taking the rate as defined by the secretary under paragraph (1) and making the following adjustments:

(A) Calendar Years 2012 – 2015: No modification

(B) Calendar Years 2016 – 2026: minus 0.5%

(C) Calendar Years 2027 and beyond: plus 1%

(c) The division shall calculate a regional medical spend benchmark in a fashion similar to subsection (a). The division shall divide the commonwealth into 3 geographic regions. The division may adjust the regions once every 5 years to account for any changes in medical operations that significantly impact the regions.

Section 47. (a) As used in this section, the following word shall have the following meaning:

“Health care entity”, a clinic, hospital, ambulatory surgical center, physician organization, accountable care organization, or payer; provided however that physician contracting units of 9 or less shall be excluded from this definition.

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

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

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

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

(f) The division shall provide notice to all health care entities within any geographic region that exceeds the regional medical spend benchmark for a given year that said benchmark has been

exceeded. Such notice shall state that the division may analyze the cost growth of individual health care entities located within such region and, beginning in calendar year 2016, may require certain actions, as established in section 48, from health care entities that are determined to have exceeded the modified potential gross state product growth rate.

(g) The division may submit a recommendation for proposed legislation to the joint committee on health care financing if the division determines that modified potential gross state product growth rate or actions under section 48 should be modified, or believes that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this act.

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

"Health care entity", a provider, physician organization, accountable care organization, or payer; however provided that physician contracting units of 9 or less shall be excluded from this definition.

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

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

(c) The health care entity may file any documentation or supporting evidence with the division to support the health care entity's application to waive or extend the requirement to file a performance improvement plan. The division shall require the health care entity to submit any other relevant information it deems necessary in considering the waiver or extension application.

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

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

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

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

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

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

(6) any other factors the division considers relevant.

(e) If the division declines to waive or extend the requirement for the health care entity to file a performance improvement plan, the division shall provide written notice to the health care entity

that its application for a waiver or extension was denied and the health care entity shall file a performance improvement plan.

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

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

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

(i) Upon approval of the proposed performance improvement plan, the division shall notify the health care entity to begin immediate implementation of the performance improvement plan.

Public notice shall be provided by the division on its website, identifying that the health care entity is implementing a performance improvement plan. All health care entities implementing an approved performance improvement plan shall be subject to additional reporting requirements and compliance monitoring, as determined by the division. The division shall provide assistance to the health care entity in the successful implementation of the performance improvement plan.

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

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

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

(m) Should the health care entity fail to successfully complete the performance improvement plan, the division may require the health care entity to resubmit a new plan consistent with this section or require the health care entity to renegotiate contracts that, in the division's opinion, are contributing to exceeding the modified potential gross state product growth rate, provided, however, that the division shall not participate in such negotiations.

(n) The division shall promulgate regulations as necessary to implement this section; provided however, that notice of any proposed regulations shall be filed with the joint committee on state

administration and regulatory oversight and the joint committee on health care financing at least 180 days before adoption.

Section 49. (a) Every provider may be subject to market impact review by the division, provided, however, that contracting units of fewer than 10 physicians shall not be subject to such review. The division shall establish, by regulation, rules for conducting market impact reviews. Such rules shall define primary service areas and dispersed service areas based on the geographic capacity of major service categories. The division shall conduct a market impact review for a provider when the division determines that market impact review is in the public interest. The division shall conduct a market impact review for any provider whose market concentration in primary or dispersed service areas exceeds the antitrust safety zone as set forth in Federal Trade Commission and Department of Justice Antitrust Division in the final policy statement of antitrust enforcement policy regarding ACOs participating in the Medicare shared savings program, 42 CFR 425. The division shall initiate a market impact review by sending such provider a notice of a market impact review which shall detail the particular factors that it seeks to examine through the review.

(b) A market impact review may examine factors including, but not limited to: (1) the provider's size and market share by major service category within its primary service areas and dispersed service areas; (2) provider price, including its relative prices filed with the division of insurance pursuant to chapter 176S; (3) provider quality, including patient experience; (4) the availability and accessibility of services similar to those provided, or proposed to be provided, through the organization within its primary service areas and dispersed service areas; (5) the provider's impact on competing options for the delivery of health care services within its primary service areas and dispersed service areas; (6) the methods used by the organization to attract patient

volume and to recruit or acquire health care professionals or facilities; (7) the role of the provider in serving at-risk, underserved and government payer patient populations within its primary service areas and dispersed service areas; (8) the role of the provider in providing low margin or negative margin services within its primary service areas and dispersed service areas; (9) the financial solvency of the provider; (10) consumer concerns, including but not limited to complaints or other allegations that the provider has engaged in any unfair method of competition or any unfair or deceptive act or practice; and (11) any other factors that the division determines to be in the public interest.

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

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

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

A. an annual report on the outcomes of payment reform which shall include, but not be limited to the achievement of benchmarks for the reduction of health care costs and improvement in quality, analyzed by region of the commonwealth, the proportion of health care expenditures reimbursed under fee-for-service and alternative payment methodologies, and trends in medical spending, including, but not limited to, cost growth trends for fee-for-service rates and alternative payment methodologies, cost growth trends for care provided within and outside of ACOs and patient-centered medical homes, and cost growth trends by provider sector, including, but not limited to, hospitals, hospital systems, non-acute providers, pharmaceuticals, medical devices and durable medical equipment;

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

C. a biannual report on patient-centered medical homes in the commonwealth which shall include, but not be limited to: the number and geographic distribution of patient-centered medical homes; the number and proportion of patient-centered medical homes which are based in primary care practices, specialty care practices, and behavioral health care practices; the number and proportion of patients receiving care in patient-centered medical homes; the number and characteristics of patients within patient-centered medical homes with complex or chronic conditions; the quality performance of patient-centered medical homes; the impact of patient-

centered medical homes on health disparities; and patient-centered medical home payment arrangements.

(b) The division shall commission an annual independent survey of patient and caregiver experience and satisfaction with the health care system, taking into account care provided by primary care providers, hospitals, ACOs and other care networks. The survey shall also assess patients' perceptions on their access to services, including, but not limited to, mental health and primary care, including, but not limited to, obstectrics and gynecology; patients' perceptions of the impact of health insurance premiums and out-of-pocket expenditures on access to care and affording other necessities; the experience of vulnerable populations such as the homeless, those with disabilities, women, the elderly and children; and differences in experience by racial, ethnic and socioeconomic background.

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

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

alerting consumers that these are estimated costs, and that the actual amount the insured will be responsible to pay for a proposed admission, procedure or service may vary.

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

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

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

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

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

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

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

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

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

The division may adopt rules to carry out this subsection and criteria for the standardized reporting and uniform allocation methodologies among ACOs. The division shall, before adopting regulations under this subsection, consult with other agencies of the commonwealth and

the federal government and affected carriers to ensure that the reporting requirements imposed under the regulations are not duplicative.

Section 54. (a) The division shall calculate a statewide median contracted price for a set of health care services provided by hospitals, physician organizations and free standing surgical centers. The division shall establish a uniform methodology to collect all necessary information to calculate such prices. The statewide median contracted price shall be calculated on an annual basis.

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

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

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

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

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

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

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

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

Section 56. (a) The division shall disseminate the data it collects under this section to consumers, health care providers and payers through (i) a publicly-accessible consumer health information website; (ii) reports on performance provided to health care providers; and (iii) any other analysis and reporting the division deems appropriate.

When collecting data, the division shall, to the extent possible, utilize existing public and private data sources and agency processes for data collection, analysis and technical assistance. The

division may enter into an interagency service agreement with other state agencies for data collection analysis and technical assistance.

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

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

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

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

(b) The division, through its rules and regulations, shall provide access to data it collects pursuant to this section. Access to data shall include, but not be limited to, disclosing to providers, on a timely basis, the contracted prices of individual health care services so as to aid in patient referrals and the management of alternative payment methodologies. Contracted prices shall be listed by provider and payer. The division shall provide data under conditions that: (i) protect patient privacy; (ii) prevent collusion or anti-competitive conduct; and (iii) prevent the release of data that could reasonably be expected to increase the cost of health care. The division may limit access to data based on its proposed use, the credentials of the requesting party, the type of data requested or other criteria required to make a determination regarding the appropriate release of the data. The division shall also limit the requesting party's use and release of any data to which that party has been given access by the division. The division shall maintain a database of health care claims submitted pursuant to this section for the purpose of conducting data analysis and preparing reports to assist in the formulation of health care policy and the provisions and purchase of health care services.

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, except as specifically otherwise provided by the council.

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

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

(d) The division shall coordinate and compile data on quality improvement programs conducted by state agencies and public and private health care organizations. The division shall consider programs designed to (i) improve patient safety in all settings of care; (ii) reduce preventable hospital readmissions; (iii) prevent the occurrence of and improve the treatment and coordination of care for chronic diseases; and (iv) reduce variations in care. The division shall make such information available on the division's consumer health information website. The division may recommend legislation or regulatory changes as needed to further implement quality improvement initiatives.

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

(b) The website shall provide updated information on a regular basis, at least annually, and additional comparative quality and price information shall be published as determined by the division. To the extent possible, the website shall include (i) comparative price information for the most common referral or prescribed services, as determined by the division, and shall be listed by facility, provider, provider group practice, ACO, or any other provider grouping, as determined by the division, provided that such information is categorized by payor; (ii) comparative quality information, as determined by division, available by facility, provider, provider group practice, ACO or any other provider grouping, as determined by the division, for each such service for which comparative price information is provided; (iii) general information related to each service for which comparative information is provided; (iv) comparative quality information, as determined by the division, available by facility, provider, provider group practice or ACO that is not service-specific, including information related to patient safety and satisfaction; (v) data concerning healthcare-associated infections and serious reportable events reported under section 51H of chapter 111; (vi) definitions of common health insurance and medical terms, including, but not limited to, those determined under sections 2715(g)(2) and (3) of the Public Service Act, so that consumers may compare health coverage and understand the terms of their coverage; (vii) a list of health care provider types, including but not limited to primary care physicians, nurse practitioners and physician assistants, and what types of services they are authorized to perform in the commonwealth under state and federal scope of practice laws; (viii) factors consumers should consider when choosing an insurance product or provider group, including, but not limited to, provider network, premium, cost-sharing, covered services, and tiering; ix) decision aids for patients to facilitate conversations with their health care providers on key health decisions, including but not limited to decision aids on long-term care

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

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

Section 58. There shall be a task force consisting of 17 members with expertise in behavioral health treatment, service delivery, the integration of behavioral health with primary care, and such reimbursement systems. Members shall include one representative from each of the following organizations representing mental health professionals and clinical, hospital and consumer advocacy groups: Massachusetts Psychiatric Society, Massachusetts Psychological Association, National Association of Social Workers- Massachusetts Chapter, Massachusetts Mental Health Counselors Association, Nurses United for Responsible Services, Massachusetts Association for Registered Nurses, Massachusetts Association of Behavioral Health Systems, Association for Behavioral Healthcare, Mental Health Legal Advisors Committee, National Alliance for the Mentally Ill, Children's Mental Health Campaign, Home Care Alliance of Massachusetts, National Empowerment Center, Massachusetts Organization for Addiction Recovery, and 3 members chosen by the Governor . The task force shall report to the division its

findings and recommendations relative to (a) the most effective and appropriate approach to including behavioral health services in the array of services provided by ACOs and patient-centered medical homes, including transition planning for providers and maintaining continuity of care; (b) how current prevailing reimbursement methods and covered behavioral health benefits may need to be modified to achieve more cost effective, integrated and high quality behavioral health outcomes including attention to interoperable electronic health records; (c) the extent to which and how payment for behavioral health services should be included under alternative payment methodologies established or regulated under this act including how mental health parity and patient choice of providers and services could be achieved and the design and use of medical necessity criteria and protocols; (d) how best to educate all providers to recognize behavioral health conditions and make appropriate decisions regarding referral to behavioral health services; and (e) the unique privacy factors required for the integration of behavioral health information into interoperatable electronic health records. The first meeting shall be convened within 60 days after passage of this act. The task force shall submit its report findings, recommendations, and any proposed legislation and regulatory changes to the joint committee on mental health and substance abuse, the joint committee on health care financing and the division no later than February 1, 2013.

Section 59. (a) There shall be in the division a health care workforce center to improve access to health care services. The center and the commissioner of labor and workforce development, shall (i) coordinate the division’s health care workforce activities with other state agencies and public and private entities involved in health care workforce training, recruitment and retention; (ii) monitor trends in access to primary care providers, nurse practitioners and physician assistants practicing as primary care providers, and other physician and nursing providers, through

activities including (1) review of existing data and collection of new data as needed to assess the capacity of the health care workforce to serve patients, including patient access and regional disparities in access to physicians, nurses or physician assistants and to examine physician, nursing and physician assistant satisfaction; (2) review existing laws, regulations, policies, contracting or reimbursement practices, and other factors that influence recruitment and retention of physicians, nurses and physician assistants; (3) making projections on the ability of the workforce to meet the needs of patients over time; (4) identifying strategies currently being employed to address workforce needs, shortages, recruitment and retention; (5) studying the capacity of public and private medical, nursing and physician assistant schools in the commonwealth to expand the supply of primary care physicians and nurse practitioners and physician assistants practicing as primary care providers; (iii) establish criteria to identify underserved areas in the commonwealth for administering the loan repayment program established under section 59 and for determining statewide target areas for health care provider placement based on the level of access; and (iv) address health care workforce shortages through the following activities, including (1) coordinating state and federal loan repayment and incentive programs for health care providers; (2) providing assistance and support to communities, physician groups, community health centers and community hospitals in developing cost-effective and comprehensive recruitment initiatives; (3) maximizing all sources of public and private funds for recruitment initiatives; (4) designing pilot programs and making regulatory and legislative proposals to address workforce needs, shortages, recruitment and retention; (5) making short-term and long-term programmatic and policy recommendations to improve workforce performance, address identified workforce shortages and recruit and retain

physicians, nurses and physician assistants; and (6) administering the health care workforce trust fund as established under section 2FFFF of chapter 29.

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

(c) The center shall annually submit a report, not later than March 1, to the Governor, 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, and 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 60. (a) There shall be a health care workforce loan repayment program, administered by the health care workforce center established by section 58. The program shall provide repayment assistance for medical school loans to participants who (i) are graduates of medical or nursing schools; (ii) specialize in family health or medicine, internal medicine, pediatrics, psychiatry or obstetrics and gynecology; (iii) demonstrate competency in health information technology at

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

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

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

Section 61. (a) As used in this section, "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.

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

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

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

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

The health care workforce center shall determine through regulation grant amounts per full-time resident. Funds for such grants shall come from the health care workforce trust fund established under section 2FFFF of chapter 29.

Section 62. Pursuant to regulations to be promulgated by the health care workforce center, there shall be established a primary care workforce development and loan forgiveness grant program at community health centers, for the purpose of enhancing recruitment and retention of primary care physicians and other clinicians at community health centers throughout the commonwealth.

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

Section 63. (a) There is hereby established within the division an office of patient protection. The office shall:—

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

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

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

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

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

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

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

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

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

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

Section 64. The division shall keep an accurate account of all its activities and of all its receipts and expenditures and shall annually make a report thereof as of the end of its fiscal year to its board, to the governor, to the general court, and to the state auditor, such reports to be in a form prescribed by the board, with the written approval of the auditor. The auditor may investigate the affairs of the division, may severally examine the properties and records of the division, and may prescribe methods of accounting and of rendering of periodic reports in relation to projects undertaken by the division. The division shall be subject to biennial audit by the state auditor.

Section 65. The division shall develop the uniform reporting of a standard set of health care quality measures for each health care provider facility, medical group, or provider group in the commonwealth hereinafter referred to as the "Standard Quality Measure Set."

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

In developing its recommendation of the Standard Quality Measure Set, the advisory committee shall, after consulting with state and national organizations that monitor and develop quality and safety measures, select from existing quality measures and shall not select quality measures that are still in development or develop its own quality measures. The committee shall annually recommend to the division any updates to the Standard Quality Measure Set by November 1. The committee may solicit for consideration and recommend other nationally recognized quality measures, including, but not limited to, recommendations from medical or provider specialty groups as to appropriate quality measures for that group's specialty. At a minimum, the Standard Quality Measure Set shall consist of the following quality measures: (i) the Centers for Medicare and Medicaid Services hospital process measures for acute myocardial infarction, congestive

heart failure, pneumonia and surgical infection prevention; (ii) the Hospital Consumer Assessment of Healthcare Providers and Systems survey; (iii) the Healthcare Effectiveness Data and Information Set reported as individual measures and as a weighted aggregate of the individual measures by medical or provider group; and (iv) the Ambulatory Care Experiences Survey.

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

Section 67. (a) As used in this section, the following words the following words shall, unless the context clearly requires otherwise, have the following meanings:-

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

"Net amount" shall mean the amount established for the estimated annual expenses of the division of health care cost and quality, established by section 2, and the health safety net office, established by section 35. This amount shall be equal to the amount appropriated by the general court for the expenses of the division of health care cost and quality and the health safety net

office minus amounts collected from (1) filing fees; (2) fees and charges generated by the division's publication or dissemination of reports and information; and (3) federal matching revenues received for these expenses or received retroactively for expenses of predecessor agencies. Estimated and actual expenses of the division and the office shall include an amount equal to the cost of fringe benefits, as established by the division of administration pursuant to section 6B of chapter 29

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

(b) Acute hospitals, as defined in section 34, ambulatory surgical centers, as defined in section 34, ACOs, as defined in section 1, and physician organizations, as defined in section 53H of chapter 111, shall pay for the estimated expenses of the division and health safety net office.

The amount to be paid for such expenses shall be equal to the net amount, as defined in subsection (g). Acute hospitals, ambulatory surgical centers, ACOs and physician organizations shall assess an administrative surcharge on all payments subject to administrative surcharge as defined in subsection (g). The administrative surcharge shall be distinct from any other amount paid by an administrative surcharge payer, as defined in subsection (g), for the services of an acute hospital, ambulatory surgical center, ACO or physician organization and shall be in addition to the surcharge imposed under section 38. The administrative surcharge amount shall equal the product of (i) the administrative surcharge percentage and (ii) amounts paid for these services by an administrative surcharge payer. The division shall calculate the administrative surcharge percentage by dividing the net amount, as defined in this section, by the projected annual aggregate payments subject to the administrative surcharge, excluding projected annual aggregate payments based on payments made by managed care organizations. The division shall subsequently adjust the administrative surcharge percentage for any variation in the net amount. The division shall determine the administrative surcharge percentage before the start of each fiscal year and may recalculate the surcharge percentage before April 1 of each fiscal year if the division projects that the initial administrative surcharge percentage established the previous October will produce less or more than the net amount in administrative surcharge payments, excluding payments made by managed care organizations, as defined in section 34. Before each succeeding October 1, the division shall recalculate the administrative surcharge percentage incorporating any adjustments from earlier years. In each calculation or recalculation of the administrative surcharge percentage, the division shall use the best data available as determined by the division and may consider the effect on projected administrative surcharge payments of any modified or waived enforcement pursuant to 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. In the event of late payment by an administrative surcharge payer, the treasurer shall advance the amount of due and unpaid funds to the division prior to the receipt of such monies in anticipation of such revenues up to the amount authorized in the then current budget attributable to the administrative surcharge, and the division shall reimburse the treasurer for such advances upon receipt of such revenues. The provisions of this paragraph shall not apply to any state institution or to any acute hospital which is operated by a city or town.

(c) Each acute hospital, ambulatory surgical center, ACO and physician organization shall bill an administrative surcharge payer an amount equal to the administrative surcharge described in this section as a separate and identifiable amount distinct from any amount paid by an administrative surcharge payer for acute hospital, ambulatory surgical center, ACO or physician organization services, and as a separate and identifiable amount distinct from any surcharge paid under section 38. Each administrative surcharge payer shall pay the administrative surcharge amount to the division. Each administrative surcharge payer shall make a preliminary payment to the division on October first of each year in an amount equal to one-half of the previous year's administrative surcharge amount. Thereafter, each administrative surcharge payer shall pay, within 30 days of the date of notice from the division, the balance of the total administrative surcharge amount for the current year. Upon the written request of an administrative surcharge payer, the division may implement another billing or collection method for the surcharge payer, provided, however, that the division has received all information that it requests which is necessary to implement such billing or collection method, and provided further, that the division

shall specify by regulation the criteria for reviewing and approving such requests and the elements of such alternative method or methods.

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

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

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

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

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

Section 68. Every health care provider, as defined in section 1 of chapter 118G, shall track and report quality information at least annually under regulations promulgated by the division. The division shall disclose quality information collected under this section and section 51H of chapter 111 to providers defined by said division.

SECTION 122. Chapter 118H of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 6 the following section:-

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

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

CHAPTER 118I. HEALTH INFORMATION TECHNOLOGY

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

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

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

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

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

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

"Health information exchange," an electronic platform enabling the transmission of healthcare-related data among providers, payers, personal health records controlled by a patient and

government agencies according to national standards, the reliable and secure transfer of data among diverse systems and access to and retrieval of data.

"Massachusetts eHealth institute" or "institute", the Massachusetts eHealth institute as created in section 3.

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

"Statewide health information exchange", a health information exchange established, operated or funded by a governmental entity or entities in the commonwealth.

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

(b) The council shall consist of 19 members, as follows: 1 shall be the secretary of health and human services or designee, who shall serve as the chair; 1 shall be the secretary of administration and finance or designee; 1 shall be the executive director of the division of health care cost and quality or designee; 1 shall be the secretary of housing and economic development or designee; 1 shall be the director of the office of Medicaid or designee; 1 shall be the commissioner of public health or designee; and 13 shall be appointed by the governor, of whom at least 1 shall be an expert in health information technology, 1 shall be an expert in law and health policy, and 1 shall be an expert in health information privacy and security; 1 shall be from

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

Chapter 268A shall apply to all council members, except that the council may purchase from, sell to, borrow from, contract with or otherwise deal with any organization in which any council member is in anyway interested or involved; provided, however, that such interest or involvement shall be disclosed in advance to the council and recorded in the minutes of the proceedings of the council; and provided further, that no member shall be deemed to have violated section 4 of said chapter 268A because of his receipt of his usual and regular

compensation from his employer during the time in which the member participates in the activities of the council.

Section 3. (a) There shall be established within the division an institute for health care innovation, technology and competitiveness, to be known as the Massachusetts e-Health Institute. The executive director of the division shall appoint a qualified individual to serve as the director of the institute, who shall be an employee of the division, report to the executive director and manage the affairs of the institute. The institute shall advance the dissemination of health information technology across the commonwealth, including the deployment of electronic health records systems in all health care provider settings that are networked through a statewide health information exchange. The institute shall (i) conduct the regional extension center program for the coordination and implementation of electronic health records systems by providers; (ii) the MassHealth electronic health records incentive program; and (iii) develop a plan to complete the implementation electronic health records systems by all providers in the commonwealth.

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

(b) The executive office shall:

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

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

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

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

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

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

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

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

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

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

providers in the community or region, particularly providers, such as community health centers that serve underserved populations, including, but not limited to, racial, ethnic and linguistic minorities, uninsured persons, and areas with a high proportion of public payer care.

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

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

Section 7. Every patient shall have electronic access to his records at all times. The executive office shall ensure that each patient will have secure electronic access to such patient's electronic health records with each of such patient's providers. The executive office shall ensure that the design of the statewide health information exchange includes the ability to transmit copies of

electronic health records to patients directly or allow facilities to provide mechanisms for such patient to access his own electronic health record.

Section 8. Not later than January 1, 2017, all providers in the commonwealth shall implement fully interoperable electronic health records systems that connect to the statewide health information exchange. The executive office shall ensure that the statewide health information exchange and associated electronic health records systems comply with all state and federal privacy requirements, including those imposed by the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, the American Recovery and Reinvestment Act of 2009, P.L. 111-5, 42 C.F.R. §§2.11 et seq. and 45 C.F.R.§§160, 162 and 164.

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

Section 10. If a provider is located in a geographic area of the commonwealth that does not have broadband internet access and, due to lack of such broadband internet access, such provider is unable to fully comply with the requirements of the health information exchange and any other health information technology requirements implemented by the executive office under this chapter, such provider may apply to the executive office for a temporary waiver of any specific requirement with which it is unable to comply. If the executive office determines that the provider is unable to comply with a requirement due to the lack of broadband internet access, the

executive office may grant a waiver of such requirement; provided, however, that, upon a determination by the executive office that broadband internet access has become available to such provider since the date of the grant of the waiver, the executive office shall notify such provider thereof. Within 180 days of such notice, such provider shall take such actions as are necessary to bring the provider into full compliance with the requirements of the health information exchange and any other health information technology requirements implemented by the executive office under this chapter.

Section 11. There shall be established and set up on the books of the executive office the Massachusetts Health Information Exchange Fund, referred to in this section as the fund, for the purpose of supporting the advancement of health information technology in the commonwealth. 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 executive office shall seek, to the greatest extent possible, private gifts, grants and donations to the fund. The executive office shall hold the fund in an account or accounts separate from other funds. The fund shall be administered by the executive office without further appropriation. Amounts credited to the fund shall be available for reasonable expenditure by the executive office, subject to the approval of the council where such approval is required under this chapter, for such purposes as the executive office determines are necessary to support the dissemination and development of the statewide health information exchange. The secretary of administration and finance shall transfer a portion of (i) any money in the E-Health Institute Fund, (ii) any money from the ONC Health Information Exchange Cooperative Agreement, or (iii) the ONC

Health Information Exchange Challenge Grant programs that is related to the implementation of the statewide health information exchange.

Section 12. There shall be established and set up on the books of the division the Massachusetts Health Information Technology Fund, referred to in this section as the fund, for the purpose of supporting the advancement of electronic health records in the commonwealth. 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 division shall seek, to the greatest extent possible, private gifts, grants and donations to the fund. The division shall hold the fund in an account or accounts separate from other funds. The fund shall be administered by the division without further appropriation. Amounts credited to the fund shall be available for reasonable expenditure by the institute, subject to the approval of the division where such approval is required under this chapter, for such purposes as the institute determines are necessary to support the dissemination, development, and deployment of the electronic health records in the commonwealth. The secretary of administration and finance shall transfer a portion of (i) monies in the E-Health Institute Fund, (ii) monies from the ONC Regional Extension Center Cooperative Agreement, or (iii) monies from the MassHealth EHR-IP contact that is related to the operation of the institute and its status as the state designated regional extension center.

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

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

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

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

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

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

Section 14. In the event of an unauthorized access to or disclosure of individually identifiable patient health information by or through the statewide health information exchange or by or through any technology grantees or implementing organizations funded in whole or in part from

the Massachusetts Health Information Technology Fund established pursuant to section 12, the operator of such exchange or grantee or contractor shall: (i) report the conditions of such unauthorized access or disclosure as required by the executive office; and (ii) provide notice, as defined in section 1 of chapter 93H, as soon as practicable, but not later than 10 business days after such unauthorized access or disclosure, to any person whose patient health information may have been compromised as a result of such unauthorized access or disclosure, and shall report the conditions of such unauthorized access or disclosure. Any unauthorized access or disclosures shall be punishable by the civil penalties as set forth in section 18.

Section 15. The ability of any provider to transfer or access all or any part of a patient's electronic health record under the provisions of this chapter shall be subject to the patient's election to participate in the electronic health information exchange as provided in section 13. Such ability shall also be subject to a separate required election to participate as to any information relating to human immunodeficiency virus status.

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

The executive office, the council and the institute shall pursue and maximize all opportunities to qualify for federal financial participation under the matching grant program established under the

Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009, P.L. 111-5. The council shall consult with the office of Medicaid to maximize all opportunities to qualify any expenditure for any other federal financial participation. Applications for funding shall be in the form and manner determined by the council, and shall include the information and assurances required by the council. The council may consider, as a condition for awarding grants, the grantee's financial participation and any other factors it deems relevant.

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

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

Section 18. (a) The state comptroller shall establish and set up on the books of the commonwealth the Massachusetts Health Information Technology Revolving Loan Fund, hereinafter referred to as the fund, for the purpose of providing loan assistance to healthcare providers, as defined in section 1 of chapter 111, to pay the costs associated with compliance with state and federal requirements relative to the implementation of health care information

technology in the commonwealth, including, but not limited to, the costs of purchasing, installing and implementing electronic health records systems and other health information technology required by state or federal law. 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 executive office shall pursue and maximize all opportunities to qualify for federal financial participation under the matching grant program established under section 3013 of the Health Information Technology for Economic and Clinical Health Act of the American Recovery and Reinvestment Act of 2009, P.L. 111-5. The department shall seek, to the greatest extent possible, private gifts, grants and donations to the fund. The fund shall be held in an account or accounts separate from other funds. The fund shall be administered by the executive office without further appropriation. Amounts credited to the fund shall be available for reasonable expenditure by the executive office, for such purposes as the executive office 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 this section. Any funds remaining in the fund at the end of a fiscal year shall be carried forward into the following fiscal year and shall remain available for expenditure without further appropriation.

(b) The executive office shall make available zero interest loan funding from the Massachusetts health information technology revolving loan fund to healthcare providers, as defined in section 1 of chapter 111, to assist with the development and implementation of an interoperable health information technology system that meets all federal and state requirements. The executive office shall make such loans available through banks approved to do business in the

commonwealth by the division of banks. The executive office shall enter into agreements with such lenders to make loans. The executive office, in consultation with the state treasurer, shall develop a lender partnership program and lender agreement that requires, at a minimum, (i) that a bank must be adequately capitalized, consistent with the requirements of 209 CMR 47.00 et seq. and as defined under the prompt corrective action provisions of the Federal Deposit Insurance Act, 12 U.S.C. section 1831(o), and the Federal Deposit Insurance Corporation's Capital Adequacy Regulations, 12 CFR section 325.103; (ii) the executive office shall specify lending standards, including without limitation, those for determining eligibility, including the eligibility standards set forth in this subsection, size and number of loans, and (iii) that all loans made under the program must be zero interest loans provided, however, that any such program may provide for reasonable application and administrative fees to be paid to lending banks under the program. A reasonable amount of administrative costs may be expended annually from the fund for the administration of the program. Any application or other fees imposed and collected under this program shall be deposited in the Massachusetts health information technology revolving loan fund for the duration of the loan program. The executive office may make such adjustments as are necessary to loan applications to account for reimbursements received under any other state or federal programs. To be eligible for a loan under this section, a healthcare provider, at a minimum, shall provide the participating lending institution 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 price quote from a vendor; (3) a description of the health care provider or entities and other groups participating in the project; (4) evidence of financial condition and ability to repay the loan; and (5) a description of how the loan funds will be used to bring the healthcare provider into compliance with federal and state requirements.

Loans shall be repaid over a 5-year term according to a schedule to be established through division regulations. The attorney general shall enforce collection of any loans in default.

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

Section 19. Unauthorized access to or disclosure of individually identifiable patient health information by or through the statewide health information exchange or by or through any technology grantees or implementing organizations funded in whole or in part from the Massachusetts Health Information Technology Fund established pursuant to section 12, or any associated businesses managing or in possession of such information, the operator of such exchange or grantee or contractor shall be subject to fines or penalties as determined by the executive office. The executive office shall promulgate regulations to assess fair and reasonable fines or penalties.

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

For the purpose of this section, advanced diagnostic imaging services shall include computerized tomography, magnetic resonance imaging, magnetic resonance angiography, positron emission

tomography, cardiac imaging, ultrasound diagnostic imaging, and such other imaging services as may be determined by the division.

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

CHAPTER 118J. ACCOUNTABLE CARE ORGANIZATIONS

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

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

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

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

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

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

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

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

"Office of patient protection", the office within the division of health care cost and quality established under section 65 of chapter 118G.

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

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

"Physician", a medical doctor licensed to practice medicine in the commonwealth.

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

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

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

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

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

(3) meet the functional capabilities under section 6;

(4) have a governance structure under section 7;

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

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

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

(8) obtain a risk certificate from the Division of Insurance as defined by section 12;

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

(10) meet pricing reporting requirements under section 15.

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

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

(e) Within 45 days of receipt of a complete application, the division shall complete its review of the application and send written notice to the ACO, with a copy to the division of insurance, explaining its decision to: (1) issue the license as applied for, (2) reject the application for failure

to comply with the requirements of the application process, with instructions that the application may be resubmitted within 10 days; or (3) deny the application.

(f) Any ACO's whose application has been rejected or denied may request an adjudicatory hearing pursuant to chapter 30A within 21 days of the division's decision. The division shall notify the attorney general and the division of insurance upon receipt of such hearing request. Said hearing shall be conducted within 30 days of the division's receipt of the hearing request. The attorney general may intervene in a hearing under this subsection and may require the production of additional information or testimony. The commissioner shall issue a written decision within 30 days of the conclusion of the hearing.

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

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

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

Section 5. ACOs shall be compensated by an alternative payment methodology for each ACO patient receiving services through the ACO, in accordance with this chapter; provided that any

and all regulations promulgated by the division shall be consistent with federal law, regulations, demonstrations and rules governing accountable care organizations and shared savings programs.

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

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

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

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

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

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

(f) Provider to provider communications functions;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) The division, in consultation with the division of insurance, shall create an annual open enrollment period for a patient to join an ACO. This period shall last no less than 1 month and no longer than 2 months. The division shall allow a patient to switch to an ACO once within the first 3 months of coverage after joining an ACO during the open enrollment period or following a qualifying event, provided that a patient who changes their health insurance outside of the ACO open enrollment period shall be provided an opportunity to enroll in a new ACO. Section 9. The ACO shall have an interoperable electronic medical record system available for ACO participants to coordinate care, share information and electronic prescribing capabilities by January 1, 2017. The division, in consultation with the Health Information Technology Council for technical advice, shall promulgate regulations related to electronic medical records including, but not limited to, the standards of interoperability, care coordination tools, information processes or electronic prescribing standards.

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

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

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

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

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

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

Section 12. The commissioner of insurance shall make a determination if an ACO has adequate reserves to meet their risk arrangements. The commissioner of insurance shall promulgate regulations to ensure the viability of an ACO for all risks including, but not limited to, global payment or shared savings risk. Upon the satisfaction of the commissioner of insurance, the division of insurance shall submit a certificate of approval to the division.

Section 13. The division shall create guidelines for ACOs to create internal appeals plans for denial of care. These guidelines shall include the clear articulation of the appellate stages, timing requirements for each stage of appeal, the process for second opinions to occur outside of the ACO. The final decision within the ACO shall be completed within 14 days after the filing of a complaint by a patient. The division may require ACOs to create an ombudsman office or similar office for the protection of patients. Once appeals within the ACO have been exhausted internally, the claims shall be appealable to the office of patient protection.

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

Section 15. The division shall require ACOs to report pricing of services by its ACO participants. The division shall require the reporting of these prices to inform the consumer under section 50 of chapter 118G. ACO participants shall have the ability to provide patients with relevant price information when contemplating their care and potential referrals.

Section 16. All accountable care organizations shall publish the standards used by the ACO to determine inclusion of any provider as an ACO participant. A provider shall be informed in writing by the ACO of the standards by which they were accepted or rejected as an ACO participant.

The division may create a review process for aggrieved providers that are denied acceptance into an ACO as an ACO participant. For such process, the division may review the following: (1) a comparison of the costs of services between an aggrieved provider and ACO participants; (2) a comparison of the quality of services between an aggrieved provider and ACO participants; (3) a

comparison of the efficiency of services between an aggrieved provider and ACO participants; and (4) the extent to which the aggrieved provider meets the published standards used by the ACO to determine inclusion of any provider as an ACO participant.

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

SECTION 126. Section 32 of chapter 123 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 5, the words “finance and policy” and inserting in place thereof the following words:—cost and quality

SECTION 127. Section 33 of chapter 123 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 20 and 25, the words “finance and policy” and inserting in place thereof, in each instance, the following words:—cost and quality

SECTION 128. Section 16 of chapter 123B of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 5, the words “finance and policy” and inserting in place thereof the following words:—cost and quality

SECTION 129. Section 6D½ of chapter 149 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 3 and 4, the words “finance and policy” and inserting in place thereof the following words:—cost and quality

SECTION 130. Chapter 149 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out section 188 and inserting in place thereof the following section:—

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

“Authority”, the commonwealth health insurance connector authority.

"Contributing employer", an employer that offers a group health plan, as defined in 26 U.S.C. 5000(b)(1), to which the employer makes a fair and reasonable premium contribution, as defined in regulation by the division of health care cost and quality .

"Department", the department of unemployment assistance.

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

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

(b) For the purpose of more equitably distributing the costs of health care provided to uninsured residents of the commonwealth, each employer that (i) employs 11 or more full-time equivalent employees in the commonwealth and (ii) is not a contributing employer shall pay a per-employee contribution at a time and in a manner prescribed by the director of unemployment assistance, in this section called the fair share employer contribution. This contribution shall be pro-rated by a fraction which shall not exceed 1, the numerator of which is the number of hours worked in the quarter by all of the employer's employees and the denominator of which is the product of the number of employees employed by an employer during that quarter multiplied by 500 hours.

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

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

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

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

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

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

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

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

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

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

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

(d) The director of unemployment assistance shall determine quarterly each employer's liability for its fair share employer contribution. The director shall assess each employer liable for a fair share employer contribution in a quarter an amount based on 25 per cent of the annual fair share employer contribution rate applicable to that quarterly period and shall implement penalties for employers who fail to make contributions as required by this section. In order to reduce the administrative costs of collection of contributions, the director shall, to the extent possible, use

any existing procedures that have been implemented by the department of unemployment assistance to make similar collections. Amounts collected pursuant to this section shall be deposited in the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29. Before depositing the amounts, the director may deduct all administrative costs incurred by the department of unemployment assistance as a result of this section, including an amount as determined by the United States Secretary of Labor in accordance with federal cost rules. Except where inconsistent with this section, the terms and conditions of chapter 151A which are applicable to the payment and collection of contributions shall apply to the same extent to the payment and collection of any obligation under this section. The department of unemployment assistance shall promulgate regulations necessary to implement this section.

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

SECTION 131. Section 46 of chapter 151A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in lines 37 through 44, paragraphs (7) and (8) of subsection (c) and inserting in place thereof the following:—

(7) to the division of health care finance and policy, information under an interagency agreement for the administration and enforcement of sections 6B and 6C of chapter 118G.

(8) to the commonwealth health insurance connector authority, information under an interagency agreement for the administration and enforcement of chapter 118H, the administration of the fair

share employer contribution requirement under section 188 of chapter 149 and the administration and enforcement of the free rider surcharge under section 17 of chapter 176Q.

SECTION 132. Section 13 of chapter 152 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 3, the words “finance and policy” and inserting in place thereof the following words:—cost and quality

SECTION 133. Section 1 of chapter 175 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after the definition of “unearned premiums” the following definition:—

“Wellness program”, a wellness program receiving a seal of approval under section 206A of chapter 111.

SECTION 134. Section 108 of chapter 175 of the General Laws, as so appearing, is hereby amended by inserting after clause 12, the following clause:—

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

SECTION 135. Chapter 175 of the General Laws, as so appearing, is hereby amended by inserting after section 108J the following 3 sections:-

Section 108K. Pursuant to section 50 of chapter 118G, not later than January 1, 2014, carriers shall provide a toll-free number and website that enables consumers to request and obtain from the carrier in real time the maximum estimated amount the insured shall be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit , based on the information available to the carrier at the time the request is made, including any

copayment, deductible, coinsurance or other out of pocket amount for any health care benefits; and a consumer disclosure alertingalerting the insured that these are estimated costs, and that the actual amount the insured will be responsible to pay for a proposed admission, procedure or service may vary.

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

Section 108M. Pursuant to section 50 of chapter 118G, carriers shall disclose patient-level data including, but not limited to, health care service utilization, medical expenses, demographics, and where services are being provided, to all providers in their network, provided that data shall be limited to patients treated by that provider, so as to aid providers in managing the care of their own patient panel.

SECTION 136. Chapter 175 of the General Laws, as so appearing, is hereby amended by inserting at the end thereof the following 4 sections:-

Section 227. As used in this section, the following words shall have the following meanings:

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

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

Pursuant to section 50 of chapter 118G, every third-party administrator shall disclose to their self-insured group clients contracted prices and quality of services of in-network providers.

Section 228. (a) A payer or any entity acting for a payer under contract, when requiring prior authorization for a health care service or benefit, shall use and accept only the prior authorization

forms designated for the specific types of services and benefits developed pursuant to subsection (c).

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

(c) The commissioner shall develop and implement uniform prior authorization forms for different health care services and benefits by July 1, 2013. The forms shall cover such health care services and benefits including but not limited to provider office visits, prescription drug benefits, imaging and other diagnostic testing, laboratory testing and any other health care services. The commissioner shall develop forms for different kinds of services as it deems necessary or appropriate; provided that all payers and any entities acting for a payer under contract must use the uniform form designated by the commissioner for the specific type of service. Six months after the full set of forms is developed, every provider shall use the appropriate uniform prior authorization form to request prior authorization for coverage of the health care service or benefit and every payer or any entity acting for a payer under contract shall accept the form as sufficient to request prior authorization for the health care service or benefit.

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

(1) The forms shall not exceed two pages;

(2) The forms shall be made electronically available;

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

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

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

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

Section 229. The commissioner shall establish standardized processes and procedures applicable to all health care providers and payers for the determination of a patient's health benefit plan eligibility at or prior to the time of service by July 1, 2013. As part of such processes and procedures, the commissioner shall (i) require payers to implement automated approval systems such as decision support software in place of telephone approvals for specific types of services specified by the commissioner and (ii) require establishment of an electronic data exchange to allow providers to determine eligibility at or prior to the point of care.

Section 230. The commissioner shall develop a summary of payments form to be used by all health care payers in the commonwealth that is provided to health care consumers with respect to provider claims submitted to a payer and written in an easily readable and understandable format showing the consumer's responsibility, if any, for payment of any portion of a health care provider claim by July 1, 2013. The summary of payments form shall include the following information: (i) provider charges; (ii) contracted rate or allowed amount; (iii) benefits provided by the payer; (iv) the consumer's co-payment; (v) the amount applied to a deductible; and (vi) any other amount not covered by the payer for which the consumer is responsible, including co-

insurance. The commissioner shall promulgate regulations to implement the requirements of this section no later than July 1, 2013.

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

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

SECTION 139. Chapter 176A of the General Laws, as so appearing, is hereby amended by inserting after section 34 the following 3 sections:—

Section 35. Pursuant to section 50 of chapter 118G, not later than January 1, 2014, every non-profit hospital service corporation shall provide a toll-free number and website that enables consumers to request and obtain from the corporation in real time the maximum estimated amount the subscriber will be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the corporation at the time the request is made, including any copayment, deductible, coinsurance or other out of pocket amount for any health care benefits; and a consumer disclosure alertingalerting the subscriber that these are estimated costs, and that the actual amount the subscriber shall be responsible to pay for a proposed admission, procedure or service may vary..

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

Section 37. Pursuant to section 50 of chapter 118G, every non-profit hospital service corporation shall disclose patient-level data including, but not limited to, health care service utilization, medical expenses, demographics, and where services are being provided, to all providers in their network, provided that data shall be limited to patients treated by that provider, so as to aid providers in managing the care of their own patient panel.

SECTION 140. Chapter 176B of the General Laws is hereby amended by inserting after section 22 the following 3 sections:-

Section 23. Pursuant to section 50 of chapter 118G, not later than January 1, 2014, every medical service corporation shall provide a toll-free number and website that enables consumers to request and obtain from the corporation in real time the maximum estimated amount the subscriber shall be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the corporation at the time the request is made, including any copayment, deductible, coinsurance or other out of pocket amount for any health care benefits; and a consumer disclosure alertingalerting the subscriber that these are estimated costs, and that the actual amount the subscriber will be responsible to pay for a proposed admission, procedure or service may vary..

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

Section 25. Pursuant to section 50 of chapter 118G, every medical service corporation shall disclose patient-level data including, but not limited to, health care service utilization, medical expenses, demographics, and where services are being provided, to all providers in their

network, provided that data shall be limited to patients treated by that provider, so as to aid providers in managing the care of their own patient panel.

SECTION 141. Chapter 176G of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 30 the following 3 sections:—

Section 31. Pursuant to section 50 of chapter 118G, not later than January 1, 2014, every health maintenance organization shall provide a toll-free number and website that enables consumers to request and obtain from the health maintenance organization in real time the maximum estimated amount the member shall be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the health maintenance organization at the time the request is made, including any copayment, deductible, coinsurance or other out of pocket amount for any health care benefits; and a consumer disclosure alertingalerting the member that these are estimated costs, and that the actual amount the member will be responsible to pay for a proposed admission, procedure or service may vary..

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

Section 33. Pursuant to section 50 of chapter 118G, every health maintenance organization shall disclose patient-level data including, but not limited to, health care service utilization, medical expenses, demographics, and where services are being provided, to all providers in their network, provided that data shall be limited to patients treated by that provider, so as to aid providers in managing the care of their own patient panel.

SECTION 142. Section 3 of chapter 176J of the General Laws, as appearing in the official 2010 edition, is hereby amended by striking out, in line 59, the word “may” and inserting in place thereof the following word:—shall.

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

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

SECTION 145. Section 11 of chapter 176J of the General Laws, as so appearing, is hereby amended at the end of the first paragraph of subsection (b) by inserting the following 2 sentences:—

Smart tiering plans may take into account the number of services performed each year by the provider. For smart tiering plans, if a medically necessary and covered service is available at only 1 facility in the state, as determined by the division of health care cost and quality, that service shall not be placed into the most expensive cost-sharing tier.

SECTION 146. Section 11 of chapter 176J of the General Laws, as so appearing, is hereby amended by inserting after subsection (g) the following 3 subsections:—

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

(i) The division shall review smart tiering plans in a manner consistent with other products offered in the commonwealth. The division may disapprove a smart tiering plan if it determines that the carrier differentiated cost-sharing obligations solely based on the provider. There shall be a rebuttable presumption that a plan has violated this subsection if the cost-sharing obligation for all services provided by a provider, including a health care facility, accountable care organization, patient centered medical home, or provider organization, is the same.

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

SECTION 147. Section 11 of chapter 176J of the General Laws, as so appearing, is hereby further amended by striking out, in line 64, the figure "12" and inserting in place thereof the following figure:—16

SECTION 148. Said section 11 of chapter 176J of the General Laws, as so appearing, is hereby further amended by inserting the following sentence at the end of subsection (a):—The division of insurance shall determine the base rate discount on an annual basis.

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

SECTION 150. Chapter 176J of the General Laws, as so appearing, is hereby amended by inserting after section 13 the following 3 sections:-

Section 14. Pursuant to section 50 of chapter 118G, not later than January 1, 2014, carriers shall provide a toll-free number and website that enables consumers to request and obtain from the carrier in real time the maximum estimated amount the member shall be responsible to pay for a proposed admission, procedure or service that is a medically necessary covered benefit, based on the information available to the carrier at the time the request is made, including any copayment, deductible, coinsurance or other out of pocket amount for any health care benefits; and a consumer disclosure alertingalerting the member that these are estimated costs, and that the actual amount the member will be responsible to pay for a proposed admission, procedure or service may vary..

Section 15. Carriers shall attribute every member to a primary care provider.

Section 16. Pursuant to section 50 of chapter 118G, every carrier shall disclose patient-level data including, but not limited to, health care service utilization, medical expenses, demographics, and where services are being provided, to all providers in their network, provided that data shall be limited to patients treated by that provider, so as to aid providers in managing the care of their own patient panel.

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

SECTION 152. Section 1 of Chapter 176O of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting before the definition of “Adverse determination” the following definition:-

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

SECTION 153. Said section 1 of chapter 176O of the General Laws, as so appearing, is hereby further amended by inserting after the definition of “Adverse determination” the following definition:—

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

SECTION 154. Said section 1 of chapter 176O of the General Laws, as so appearing, is hereby further amended by inserting after the definition of “Emergency medical condition” the following definition:-

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

SECTION 155. Said section 1 of said chapter 176O of the General Laws is hereby further amended by inserting after the definition of “Participating provider” the following definition:-

“Patient centered medical home”, a patient centered medical home as defined in section 45 of 118G.

SECTION 156. Said section 1 of chapter 176O of the General Laws, as so appearing, is hereby further amended by inserting after the definition of “Health care services” the following new definition:—

"Hospital-based physician", a pathologist, anesthesiologist, radiologist or emergency room physician who practices exclusively within the inpatient or outpatient hospital setting and who provides health care services to a carrier's insured only as a result of the insured being directed to the hospital inpatient or outpatient setting. This definition may be expanded, after consultation with a statewide advisory committee composed of an equal number of organizations representing providers and those representing health plans, including, but not limited to, a representative from the Massachusetts Medical Society, the Massachusetts Hospital Association, the Massachusetts Association of Health Plans, the Massachusetts Association of Medical Staff Services, and Blue Cross Blue Shield of Massachusetts, by regulation to include additional categories of physicians who practice exclusively within the inpatient or outpatient hospital setting and who provide health care services to a carrier's insured only as a result of the insured being directed to the hospital inpatient or outpatient setting.

SECTION 157. Said section 1 of chapter 176O of the General Laws, as so appearing, is hereby further amended by striking out in lines 126 to 128 the definition of "Office of patient protection" and inserting in place thereof the following:—

"Office of patient protection", the office in the division of health care cost and quality established by section 65 of chapter 118G, responsible for the administration and enforcement of sections 13, 14, 15 and 16.

SECTION 158. Said section 1 of chapter 176O of the General Laws, as so appearing, is hereby further 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 259. Said section 1 of chapter 176O of the General Laws, as so appearing, is hereby further amended by inserting after the definition of "Prospective review" the following definition:-

"Physician organization", a physician organization as defined in section 53H of chapter 111.

SECTION 160. Section 2 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out, in lines 22 and 23, the words "finance and policy" and inserting, in each instance, in place thereof the following words:—cost and quality

SECTION 161. Said section 2 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out subsection (c) and inserting in place thereof the following subsection:—

(c) Regulations promulgated by the bureau shall be consistent with and not duplicate or overlap with the regulations promulgated by the office of patient protection in the division of health care cost and quality established by section 65 of chapter 118G.

SECTION 162. Chapter 176O of the General Laws, as so appearing, is hereby amended by inserting after section 2 the following 2 new sections:—

Section 2A. (a) The bureau shall adopt a common application for initial credentialing or appointment and a common application for re-credentialing or reappointment. The bureau, after consultation with a statewide advisory committee composed of an equal number of organizations representing providers and those representing health plans, including, but not limited to, a representative from the Massachusetts Medical Society, the Massachusetts Hospital Association,

the Massachusetts Association of Health Plans, the Massachusetts Association of Medical Staff Services, and Blue Cross Blue Shield of Massachusetts, a representative of the board of registration in medicine, a representative of the board of registration in nursing and a representative of the department of public health, shall adopt and make any revisions to the common credentialing application forms that includes, but is not limited to, applicable accreditation as well as federal and state regulatory changes that will impact such forms. Such forms shall not be applicable in those instances where the carrier has both delegated credentialing to a provider organization and does not require submission of a credentialing application.

(b) A carrier and a participating provider shall not use any initial physician credentialing application form other than the uniform initial physician application form or a uniform electronic version of said form. A carrier and a participating provider shall not use any physician re-credentialing application form other than the uniform physician re-credentialing application form or a uniform electronic version of said form. A carrier may require that a physician profile be submitted in addition to the uniform physician re-credentialing application form.

(c) A carrier shall act upon and complete the credentialing process for 95 per cent of complete initial physician credentialing applications submitted by or on behalf of a physician applicant within 30 calendar days of receipt of a complete application. An application shall be considered complete if it contains all of the following elements submitted by the physician applicant or designee or obtained by the carrier from a credentials verification organization certified by the National Committee for Quality Assurance: —

(i) the application form is signed and appropriately dated by the physician applicant;

(ii) all information on the application is submitted in a legible and complete manner and any affirmative answers are accompanied by explanations satisfactory to the carrier;

(iii) a current curriculum vitae with appropriate required dates;

(iv) a signed, currently dated Applicant's Authorization to Release Information form;

(v) copies of the applicant's current licenses in all states in which the physician practices;

(vi) a copy of the applicant's current Massachusetts controlled substances registration and a copy of the applicant's current federal DEA controlled substance certificate or, if not available, a letter describing prescribing arrangements;

(vii) a copy of the applicant's current malpractice face sheet coverage statement including amounts and dates of coverage;

(viii) hospital letter or verification of hospital privileges or alternate pathways;

(ix) documentation of board certification or alternate pathways;

(x) documentation of training, if not board certified;

(xi) there are no affirmative responses on questions related to quality or clinical competence;

(xii) there are no modifications to the Applicant's Authorization to Release Information Form;

(xiii) there are no discrepancies between the information submitted by or on behalf of the physician and information received from other sources; and

(xiv) the appropriate health plan participation agreement, if applicable.

(d) A carrier shall report to a physician applicant or designee the status of a submitted initial credentialing application within a reasonable timeframe. Said report shall include, but not be limited to, the application receipt date and, if incomplete, an itemization of all missing or incomplete items. A carrier may return an incomplete application to the submitter. A physician applicant or designee shall be responsible for any and all missing or incomplete items.

(e) A carrier shall notify a physician applicant of the carrier's credentialing committee's decision on an initial credentialing application within 4 business days of the decision. Said notice shall include the committee's decision and the decision date.

(f) A physician, other than a primary care provider compensated on a capitated basis, who has been credentialed pursuant to the terms of this section shall be allowed to treat a carrier's insureds and shall be reimbursed by the carrier for covered services provided to a carrier's insureds effective as of the carrier's credentialing committee's decision date. A primary care physician compensated on a capitated basis who has been credentialed pursuant to the terms established in this section shall be allowed to treat a carrier's insureds and shall be reimbursed by the carrier for covered services provided to the carrier's insureds effective no later than the first day of the month following the carrier's credentialing committee's decision date.

(g) This section shall not apply to the credentialing and re-credentialing by carriers of psychiatrists or hospital-based physicians.

Section 2B. (a) The bureau's accreditation requirements related to credentialing and re-credentialing shall not require a carrier to complete the credentialing or re-credentialing process for hospital-based physicians.

(b) Except as provided in paragraph (d), a carrier shall not require a hospital-based physician to complete the credentialing and re-credentialing process established pursuant to the bureau's accreditation requirements.

(c) A carrier may establish an abbreviated data submission process for hospital-based physicians. Except as provided in paragraph (d) of this section, said process shall be limited to a review of the data elements required to be collected and reviewed pursuant to applicable federal and state regulations as well as national accreditation organization standards.

(d) In the event that the carrier determines that there is a need to further review a hospital-based physician's credentials due to quality of care concerns, complaints from insureds, applicable law or other good faith concerns, the carrier may conduct such review as is necessary to make a credentialing or re-credentialing decision.

(e) Nothing in this section shall be construed to prohibit a carrier from requiring a physician to submit information or taking other actions necessary for the carrier to comply with the applicable regulations of the board of registration in medicine.

(f) The bureau, after consultation with a statewide advisory committee composed of an equal number of organizations representing providers and those representing health plans including but not limited to a representative from the Massachusetts Hospital Association, the Massachusetts Medical Society, the Massachusetts Association of Health Plans, the Massachusetts Association of Medical Staff Services, and Blue Cross and Blue Shield of Massachusetts, a representative of the board of registration in medicine, a representative of the board of registration in nursing and a representative of the department of public health, shall develop standard criteria and oversight

guidelines that may be used by carriers to delegate the credentialing function to providers. Such criteria and oversight guidelines shall meet applicable accreditation standards.

SECTION 163. Section 5B of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out, in lines 11 and 12, the words "finance and policy, the Massachusetts health care quality and cost council," and inserting, in each instance, in place thereof the following words:—cost and quality

SECTION 164. Section 6 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking clause (3) of subsection (a) and inserting in place thereof the following clause:—

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

SECTION 165. Said section 6 of chapter 176O of the General Laws, as so appearing, is hereby further amended by striking out, in lines 52 to 54, paragraph (13) and inserting in place thereof the following paragraph:—

(13) a statement on how to obtain the report regarding grievances from the office of patient protection pursuant to paragraph (2) of subsection (a) of section 65 of chapter 118G;

SECTION 166. Section 7 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out, in line 45, the words “department of public health” and inserting in place thereof the following:—division of health care cost and quality

SECTION 167. Section 9A of chapter 176O of the General Laws, as so appearing, is hereby amended by inserting after subsection (c), the following 2 subsections:—

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

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

SECTION 168. Section 14 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out, in line 6, the words “section 217 of chapter 111” and inserting in place thereof the following words:—section 65 of chapter 118G

SECTION 169. Chapter 176O of the General Laws, as so appearing, 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 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 physician 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 physician is not a participating provider, and (2) said physician is providing the insured with an ongoing course of treatment or is the insured's primary care provider. With respect to an 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 170. Section 20 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out, in lines 26 to 30, paragraph (iv)(3) and inserting in place thereof the following paragraph:—

(3) a statement that the office of patient protection, established by section 65 of chapter 118G, is available to assist consumers, a description of the grievance and review processes available to consumers under chapter 176O, and relevant contact information to access the office and these processes.

SECTION 171. Section 21 of chapter 176O of the General Laws, as so appearing, is hereby amended by striking out, in line 109, the words “finance and policy” and inserting in place thereof the following words:—cost and quality

SECTION 172. Chapter 176O of the General Laws is hereby amended by inserting at the end thereof the following 2 sections:-

Section 22. (a) Accountable care organizations, patient centered medical homes, or physician organizations who are paid through an alternative payment methodology with shared risk shall create internal appeals processes. The processes shall be available to the public in both written format and available by request in electronic format.

(b) The internal appeals processes in subsection (a) shall (A) be completed in a period no longer than 14 days, provided that an expedited internal appeal shall be completed in a period no longer that 3 days for a patient with a terminal illness; and (B) offer an external opinion unless it would be impractical for expedited internal appeals.

(c) Accountable care organizations and patient centered medical homes, with an approval from the executive director, shall designate a third party as an ombudsman. Said ombudsman shall act as an advocate for patients, provided that for any patient who elects to have an independent care coordinator, said care coordinator may act as the patient advocate.

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

Section 23. (a) Accountable care organizations, patient centered medical homes, or physician organizations who are paid through an alternative payment methodology with shared risk shall provide an external second opinion. The external second opinion shall be conducted by a provider who is not a member of the global payment risk sharing arrangement.

SECTION 173. Section 1 of chapter 176Q of the General Laws, as so appearing, is hereby amended by striking out, in line 23, the words "finance and policy" and inserting in place thereof the following words:—cost and quality

SECTION 174. Chapter 176Q of the General Laws, as so appearing, is hereby amended by adding the following section:—

Section 17. (a) The authority shall, upon verification of the provision of services and costs to a state-funded employee, assess a free rider surcharge on the non-providing employer under regulations promulgated by the authority.

(b) The amount of the free rider surcharge on non-providing employers shall be determined by the authority under regulations promulgated by the authority, and assessed by the authority not later than 3 months after the end of each hospital fiscal year, with payment by non-providing employers not later than 180 days after the assessment. The amount charged by the authority shall be greater than 10 per cent but no greater than 100 per cent of the cost to the state of the services provided to the state-funded employee, considering all payments received by the state from other financing sources for free care; provided that the "cost to the state" for services provided to any state-funded employee may be determined by the authority as a percentage of the state's share of aggregate costs for health services. The free rider surcharge shall only be

triggered upon incurring $50,000 or more, in any hospital fiscal year, in free care services for any employer's employees, or dependents of such persons, in aggregate, regardless of how many state-funded employees are employed by that employer.

(c) The formula for assessing free rider surcharges on non-providing employers shall be set forth in regulations promulgated by the authority that shall be based on factors including, but not limited to: (i) the number of incidents during the past year in which employees of the non-providing employer received services reimbursed by the health safety net office under section 39; (ii) the number of persons employed by the non-providing employer; (iii) the proportion of employees for whom the non-providing employer provides health insurance.

(d) If a state-funded employee is employed by more than one non-providing employer at the time he or she receives services, the authority shall assess a free rider surcharge on each said employer consistent with the formula established by the authority under this section.

(e) The authority shall specify by regulation appropriate mechanisms for implementing free rider surcharges on non-providing employers. Said regulations shall include, but not be limited to, the following provisions:—

(i) Appropriate mechanisms that provide for determination and payment of surcharge by a non-providing employer including requirements for data to be submitted by employers, employees, acute hospitals and ambulatory surgical centers, and other persons; and

(ii) Penalties for nonpayment or late payment by the non-providing employer, including assessment of interest on the unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees or penalties at a rate not to exceed 5 per cent per month.

(f) All surcharge payments made under this section shall be deposited into the Commonwealth Care Trust Fund, established by section 2OOO of chapter 29.

(g) A non-providing employer's liability to that fund shall in the case of a transfer of ownership be assumed by the successor in interest to the non-providing employer's.

(h) If a non-providing employer fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the authority, the authority shall provide written notice of the required information. If the employer fails to provide information within 2 weeks of receipt of said notice, or if it falsifies the same, it shall be subject to a civil penalty of not more than $5,000 for each week on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction.

(i) The attorney general shall bring any appropriate action, including injunctive relief, as may be necessary for the enforcement of this chapter.

(j) No employer shall discriminate against any employee on the basis of the employee's receipt of free care, the employee's reporting or disclosure of his employer's identity and other information about the employer, the employee's completion of a Health Insurance Responsibility Disclosure form, or any facts or circumstances relating to "free rider" surcharges assessed against the employer in relation to the employee. Violation of this subsection shall constitute a per se violation of chapter 93A.

(k) A hospital, surgical center, health center or other entity that provides uncompensated care pool services shall provide an uninsured patient with written notice of the criminal penalties for committing fraud in connection with the receipt of uncompensated care pool services. The

authority shall promulgate a standard written notice form to be made available to health care providers in English and foreign languages. The form shall further include written notice of every employee's protection from employment discrimination under this section.

SECTION 175. 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 meanings 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.

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

"Physician assistant", a person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician in accordance with sections 9C to 9H, inclusive, of chapter 112, and who has passed the Physician Assistant National Certifying Exam or its equivalent.

"Primary care provider", a health care professional qualified to provide general medical care for common health care problems who (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 authority as defined by statute, rule and physician delegation to the extent that such policy or contract currently provides benefits for identical services rendered by a provider of health care licensed by the commonwealth.

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

Section 4. Notwithstanding any general or special law to the contrary, a carrier that requires the designation of a primary care provider shall provide its insured with an opportunity to select a participating provider physician assistant as a primary care provider.

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

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

SECTION 176. Section 8A of chapter 180 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 101, the words “finance and policy” and inserting in place thereof the following words:—cost and quality

SECTION 177. Section 9 of chapter 209C of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 37, the words “finance and policy” and inserting in place thereof the following words:—cost and quality

SECTION 178. Section 60K of chapter 231 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended in line 14 by striking the number “4” and inserting in place thereof the following number:— 3

SECTION 179. Section 85K of chapter 231 of the General Laws, as so appearing, is hereby amended by inserting after the word “costs”, in line 8, with the following words:—

; provided, however, in the context of medical malpractice claims against a non-profit charity providing health care, such cause of action shall not exceed the sum of $100,000, exclusive of interest and costs.

SECTION 180. Chapter 231 of the General Laws, as so appearing, is hereby amended by inserting after section 60K the following 3 sections:—

Section 60L. (a) Except as provided in this section a person shall not commence an action against a provider of health care as defined in the seventh paragraph of section 60B unless the person has given the health care provider written notice under this section of not less than 182 days before the action is commenced.

(b) The notice of intent to file a claim required under subsection (a) shall be mailed to the last known professional business address or residential address of the health care provider who is the subject of the claim.

(c) The 182 day notice period in subsection (a) shall be shortened to 91 days if either of the following conditions exists:

(1) the claimant has previously filed the 182 day notice required against another health care provider involved in the claim; and

(2) the claimant has filed a complaint and commenced an action alleging medical malpractice against 1 or more of the health care providers involved in the claim.

(d) The 182 day notice of intent described in subsection (a) shall not be required if the claimant did not identify and could not reasonably have identified a health care provider to which notice must be sent as a potential party to the action before filing the complaint.

(e) The notice given to a health care provider under this section shall contain a statement of at least all of the following:

(1) the factual basis for the claim;

(2) the applicable standard of care alleged by the claimant;

(3) the manner in which it is claimed that the applicable standard of care was breached by the health care provider;

(4) the alleged action that should have been taken to achieve compliance with the alleged standard of care;

(5) the manner in which it is alleged the breach of the standard of care was a proximate cause of the injury claimed in the notice; and

(6) the names of all health care providers the claimant is notifying under this section in relation to the claim.

(f) Fifty-six days after giving notice under this section, the claimant shall allow the health care provider receiving the notice access to all of the medical records related to the claim that are in the claimant's control, and shall furnish release for any medical records related to the claim that are not in the claimant's control, but of which the claimant has knowledge. This subsection does not restrict a patient's right of access to his or her medical records under any other provision of law.

(g) Within 150 days after receipt of notice under this section, the health care provider or authorized representative against whom the claim is made shall furnish to the claimant or his or her authorized representative a written response that contains a statement including the following:

(1) the factual basis for the defense, if any, to the claim;

(2) the standard of care that the health care provider claims to be applicable to the action;

(3) the manner in which it is claimed by the health care provider that there was or was not compliance with the applicable standard of care; and

(4) the manner in which the health care provider contends that the alleged negligence of the health care provider was or was not a proximate cause of the claimant's alleged injury or alleged damage.

(h) If the claimant does not receive the written response required under subsection (g) within the required 150 day time period, the claimant may commence an action alleging medical malpractice upon the expiration of the 150 day period. Further, if a provider fails to respond within 150 days and that fact is made known to the Court in the plaintiffs' complaint or by any other means then interest on any judgment against that provider will accrue and be calculated from the date that the notice was filed rather than the date that suit is filed. At any time before the expiration of the 150 day period, the claimant and the provider may agree to an extension of the 150 day period.

(i) If at any time during the applicable notice period under this section a health care provider receiving notice under this section informs the claimant in writing that the health care provider does not intend to settle the claim within the applicable notice period, the claimant may commence an action alleging medical malpractice against the health care provider, so long as the claim is not barred by the statute of limitations or repose.

(j) As to any lawsuit against any health care provider filed within 6 months of the statute of limitations expiring as to any claimant, or within 1 year of the statute of repose expiring as to any claimant, compliance with this section is not required.

(k) Nothing in this act shall prohibit the filing of suit at any time in order to seek court orders to preserve and permit inspection of tangible evidence.

Section 60M. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider of health licensed pursuant to section 2 of chapter 112, including actions pursuant to section 60B, an expert witness shall have been engaged in the practice of medicine at the time of the alleged wrongdoing.

Section 60N. In any action for malpractice, negligence, error, omission, mistake or the unauthorized rendering of professional services against a provider of health licensed pursuant to section 2 of chapter 112, including actions pursuant to section 60B of this chapter, an expert witness shall be board certified in the same specialty as the defendant physician as licensed pursuant to section 2 of chapter 112.

SECTION 181. Chapter 233 of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by inserting after section 79K the following section:-

Section 79L. (a) As used in this section the following terms shall have the following meaning:

"Health Care Provider", means any of the following heath care professionals licensed pursuant to chapter 112: a physician, physician assistant, podiatrist, physical therapist, occupational therapist, dentist, optometrist, nurse, nurse practitioner, chiropractor, psychologist, independent clinical social worker, speech-language pathologist, audiologist, marriage and family therapist and a mental health counselor. The term shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such health care providers.

"Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health agency. The term shall also include any corporation, professional corporation, partnership, limited liability company, limited liability partnership, authority, or other entity comprised of such facilities.

"Unanticipated outcome" means the outcome of a medical treatment or procedure, whether or not resulting from an intentional act, that differs from an intended result of such medical treatment or procedure.

(b) In any claim, complaint or civil action brought by or on behalf of a patient allegedly experiencing an unanticipated outcome of medical care, any and all statements, affirmations, gestures, activities or conduct expressing benevolence, regret, apology, sympathy, commiseration, condolence, compassion, mistake, error, or a general sense of concern which are made by a health care provider, facility or an employee or agent of a health care provider or facility, to the patient, a relative of the patient, or a representative of the patient and which relate to the unanticipated outcome shall be inadmissible as evidence in any judicial or administrative proceeding, unless the maker of the statement or a defense expert witness, when questioned under oath during the litigation about facts and opinions regarding any mistakes or errors that occurred, makes a contradictory or inconsistent statement as to material facts or opinions, in which case the statements and opinions made about the mistake or error are admissible for all purposes. In situations where a patient suffers an unanticipated outcome with significant medical complication resulting from the provider's mistake, the health care provider, facility, or an employee or agent of a health care provider or facility shall fully inform the patient, and when appropriate the patient's family, about said unanticipated outcome.

SECTION 182. Section 3 of chapter 258C of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 36, the words "finance and policy" and inserting in place thereof the following words:—cost and quality

SECTION 183. Section 7 of chapter 268A of the General Laws, as appearing in the 2010 Official Edition, is hereby amended by striking out, in line 50, the words "policy and finance" and inserting in place thereof the following words:—cost and quality

SECTION 184. Section 27 of chapter 141 of the acts of 2000 is hereby amended by striking out the words “Health Insurance Consumer Protections” and inserting in place thereof the following words:- Health Care Consumer Protections.

SECTION 185. Section 1 of chapter 205 of the acts of 2007 is hereby repealed.

SECTION 186. Sections 3, 4, 15 and 15 of chapter 305 of the acts of 2008 are hereby repealed.

SECTION 187. Sections 2, 3 and 54 of chapter 288 of the acts of 2010 are hereby repealed.

SECTION 188. Nothing in this act shall be construed to preclude an individual from obtaining additional insurance or paying out of pocket for any medical service not covered by the individual’s health plan, provided, however, that supplemental insurance may not cover copayments, deductibles, co-insurance or other patient payment responsibility for services that are included in the individual’s health plan.

SECTION 189. To promote the adoption of alternative payment methodologies and contracting with ACOs by both private and public purchasers of health care, the division of health care cost and quality shall, by August 15, 2012, request from the federal office of the inspector general the following:

(i) a waiver of the provisions of, or expansion of the “safe harbors” to, 42 U.S.C. section 1320a-7b and implementing regulations or any other necessary authorization the division determines may be necessary to permit certain shared risk and other risk sharing arrangements among providers and ACOs; and

(ii) a waiver of or exemption from the provisions of 42 U.S.C. section 1395nn(a) to (e) and implementing regulations or other necessary authorization the division determines may be

necessary to permit physician referrals to other providers as needed to support the transition to and implementation of alternative payment systems and formation of ACOs.

SECTION 190. Notwithstanding any general or special law, rule or regulation to the contrary, the commissioner of insurance shall promulgate regulations requiring any carrier, as defined in chapter 176O of the general laws, and their contractors to effectively comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008, Section 511 of Public Law 110-343. The commissioner of insurance shall promulgate said regulations not later than 90 days after the effective date of this act. Said regulations shall be implemented as part of any provider contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed, or amended on or after this act's effective date.

Starting on July 1, 2013, the commissioner of insurance shall require all carriers, as so defined, and their contractors, to submit an annual report to the division of insurance, which shall be a public record, certifying and outlining how their health benefit plans are in compliance with the federal Mental Health Parity Act and the provisions of this section. The division of insurance shall forward all such reports to the office of the attorney general for verification of compliance with the federal Mental Health Parity Act.

SECTION 191. Notwithstanding any general or special law, rule or regulation to the contrary, the office of Medicaid shall promulgate regulations requiring any Medicaid health plan and managed care organization and their health plans and any behavioral health management firm and third party administrator under contract with a Medicaid managed care organization to effectively comply with and implement the federal Mental Health Parity and Addiction Equity Act of 2008, Section 511 of Public Law 110-343. The office of Medicaid shall promulgate said

regulations not later than 90 days after the effective date of this act. Said regulations shall be implemented as part of any provider contracts and any carrier's health benefit plans which are delivered, issued, entered into, renewed, or amended on or after this act's effective date.

Starting on July 1, 2013, the office of Medicaid shall submit an annual report to the co-chairs of the joint committee on health care financing, the co-chairs of the joint committee on mental health and substance abuse, the clerk of the senate, and the clerk of the house of representatives certifying and outlining how the health benefit plans under the office of Medicaid, and any contractors, are in compliance with the federal Mental Health Parity Act and the provisions of this section. The office of Medicaid shall forward all such reports to the office of the attorney general for verification of compliance with the federal Mental Health Parity Act.

SECTION 192. Notwithstanding any law or regulation to the contrary, the group insurance commission, office of Medicaid, and the commonwealth connector authority may offer smart tiered plans, as defined in section 11 of chapter 176J, on January 1, 2014.

SECTION 193. (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 of the following functions of state government from the transferor agency to the transferee agency, defined as follows: the functions of the Massachusetts eHealth Institute, established under section 6D of chapter 40J of the General Laws, as the transferor agency, to the division of health care cost and quality established under section 2 of chapter 118G of the General Laws, as the transferee agency.

(b) The employees of the transferor agency, including those who were appointed immediately before the effective date of this act and who hold permanent appointment in positions classified

under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are hereby transferred to the transferee agency, without interruption of service within the meaning of said section 9A of said chapter 31, without impairment of seniority, retirement or other rights of the employee, and without reduction in compensation or salary grade, notwithstanding any change in title or duties resulting from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and benefits, and without change in union representation or certified collective bargaining unit as certified by the state department of labor relations or in local union representation or affiliation. Any collective bargaining agreement in effect immediately before the transfer date shall continue in effect and the terms and conditions of employment therein shall continue as if the employees had not been so transferred. The reorganization shall not impair the civil service status of any such reassigned employee who immediately before the effective date of this act either holds a permanent appointment in a position classified under chapter 31 of the General Laws or has tenure in a position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding any other general or special law to the contrary, all such employees shall continue to retain their right to collectively bargain pursuant to chapter 150E of the General Laws and shall be considered employees for the purposes of said chapter 150E. Nothing in this section shall be construed to confer upon any employee any right not held immediately before the date of said transfer, or to prohibit any reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or abolition of position not prohibited before such date.

(c) All petitions, requests, investigations and other proceedings appropriately and duly brought before the transferor agency or duly begun by the transferor agency and pending before the

effective date of this act, shall continue unabated and remain in force, but shall be assumed and completed by the transferee agency.

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

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

(f) All duly existing contracts, leases and obligations of the transferor agency shall continue in effect but shall be assumed by the transferee agency.

(g) The comptroller shall be authorized to take any actions necessary to support the transfers outlined in this section. No existing right or remedy of any character shall be lost, impaired or affected by this act.

SECTION 194. (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 of the following functions of state government from the transferor agency to the transferee agency, defined as follows: the functions of the Massachusetts Health Information Technology Council, established under section 6D of chapter 40J of the General Laws, as the transferor agency, to the executive office of health and human services, as the transferee agency.

(b) The employees of the transferor agency, including those who were appointed immediately before the effective date of this act and who hold permanent appointment in positions classified under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are hereby transferred to the transferee agency, without interruption of service within the meaning of said section 9A of said chapter 31, without impairment of seniority, retirement or other rights of the employee, and without reduction in compensation or salary grade, notwithstanding any change in title or duties resulting from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and benefits, and without change in union representation or certified collective bargaining unit as certified by the state department of labor relations or in local union representation or affiliation. Any collective bargaining agreement in effect immediately before the transfer date shall continue in effect and the terms and conditions of employment therein shall continue as if the employees had not been so transferred. The reorganization shall not impair the civil service status of any such reassigned employee who immediately before the effective date of this act either holds a permanent appointment in a position classified under chapter 31 of the General Laws or has tenure in a position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding any other general or special law to the contrary, all such employees shall continue to retain their right to collectively bargain pursuant to chapter 150E of the General Laws and shall be considered employees for the purposes of said chapter 150E. Nothing in this section shall be construed to confer upon any employee any right not held immediately before the date of said transfer, or to prohibit any reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or abolition of position not prohibited before such date.

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

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

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

(f) All duly existing contracts, leases and obligations of the transferor agency shall continue in effect but shall be assumed by the transferee agency.

(g) The comptroller shall be authorized to take any actions necessary to support the transfers outlined in this section. No existing right or remedy of any character shall be lost, impaired or affected by this act.

SECTION 195. (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 of the following functions of state government from the transferor agency to the transferee agency, defined as follows: the functions of the division of health care finance and

policy, as the transferor agency, to the division of health care cost and quality, as the transferee agency.

(b) The employees of the transferor agency, including those who were appointed immediately before the effective date of this act and who hold permanent appointment in positions classified under chapter 31 of the General Laws or have tenure in their positions as provided by section 9A of chapter 30 of the General Laws or do not hold such tenure, or hold confidential positions, are hereby transferred to the transferee agency, without interruption of service within the meaning of said section 9A of said chapter 31, without impairment of seniority, retirement or other rights of the employee, and without reduction in compensation or salary grade, notwithstanding any change in title or duties resulting from such reorganization, and without loss of accrued rights to holidays, sick leave, vacation and benefits, and without change in union representation or certified collective bargaining unit as certified by the state department of labor relations or in local union representation or affiliation. Any collective bargaining agreement in effect immediately before the transfer date shall continue in effect and the terms and conditions of employment therein shall continue as if the employees had not been so transferred. The reorganization shall not impair the civil service status of any such reassigned employee who immediately before the effective date of this act either holds a permanent appointment in a position classified under chapter 31 of the General Laws or has tenure in a position by reason of section 9A of chapter 30 of the General Laws. Notwithstanding any other general or special law to the contrary, all such employees shall continue to retain their right to collectively bargain pursuant to chapter 150E of the General Laws and shall be considered employees for the purposes of said chapter 150E. Nothing in this section shall be construed to confer upon any employee any right not held immediately before the date of said transfer, or to prohibit any

reduction of salary grade, transfer, reassignment, suspension, discharge, layoff, or abolition of position not prohibited before such date.

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

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

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

(f) All duly existing contracts, leases and obligations of the transferor agency shall continue in effect but shall be assumed by the transferee agency.

(g) The comptroller shall be authorized to take any actions necessary to support the transfers outlined in this section. No existing right or remedy of any character shall be lost, impaired or affected by this act.

SECTION 196. Notwithstanding any general or special law to the contrary, the secretary of health and human services shall transfer any remaining funds from the distressed provider

expendable trust fund, established in chapter 241 of the acts of 2004, to the distressed hospital trust fund, established in section 2GGGG of chapter 29 of the General Laws.

SECTION 197. Notwithstanding any general or special law to the contrary, the division of health care cost and quality, established under chapter 118G, shall continue to collect all assessments formerly collected by the division of health care finance and policy, including, without limitation, health safety net assessments, nursing home user fees and child immunization assessments.

SECTION 198. If any provision of this act or its application to any entity, person or circumstance is held invalid by a court of competent jurisdiction, the invalidity shall not affect other provisions or applications of this act that can be given effect without the invalid provision or application, and to this end the provisions of the act are severable.

SECTION 199. Notwithstanding any law or regulation to the contrary, the division of insurance shall conduct a study on the adequacy of reserves for both payers and providers. The study shall include the following: (1) current reserves held by payers, (2) current reserves held by providers, (3) a formula to calculate the minimum necessary reserves for payors based on their levels of risk, (4) a formula to calculate the minimum necessary reserves for providers based on their levels of risk, and (5) a threshold of excess reserves. Minimum necessary reserves shall mean the amount of reserves required for a payer or provider to be fiscally solvent. The threshold of excess reserves shall represent an amount beyond what a payer or provider should reasonably hold above the necessary reserves amount. The level of risk shall mean the possible percentages of risk a provider or payer has in any risk sharing arrangement. Upon completion of this study, the division shall promulgate all necessary regulations to implement the findings of the study.

The division shall then issue a report on its findings to the senate and house committees on ways and means and the joint committee on health care financing by July 1, 2013.

SECTION 200. Notwithstanding any law or rule the contrary, the health care workforce center shall investigate the possibility of dedicating funds for joint appointments for clinicians with clinical agencies and universities. As part of the arrangement, clinicians pursuing doctoral education would receive tuition and fee reimbursement for maintaining a clinical position and teaching at the entry level of the academic program while pursuing their doctoral degree.

SECTION 201. Section 146 and 147 shall take effect on January 1, 2016.