Chapter 224 of the Acts of 2012
Section by Section Summary

Section #	Topic	Summary
1	Technical Amendment	Relative to the Division of Health Care Finance and Policy (DHCFP) and the Center for Health Information and Analysis (CHIA).
2	Technical Amendment	Relative to DHCFP and CHIA.
3	Technical Amendment	Relative to repeal of the Health Care Quality and Cost Council (QCC).
4	Technical Amendment	Relative to DHCFP and CHIA.
5	Technical Amendment	Relative to DHCFP and MassHealth.
6	Betsy Lehman Center	Repeals the Betsy Lehman Center.
7	QCC	Repeals the QCC.
8	Technical Amendment	Relative to DHCFP and CHIA.
9	Technical Amendment	Relative to DHCFP and CHIA.
10	Technical Amendment	Relative to DHCFP and CHIA.
11	Technical Amendment	Relative to DHCFP and CHIA.
12	Technical Amendment	Relative to DHCFP and CHIA.
13	Technical Amendment	Removes a reference to the QCC.
14	Health Planning Council	Creates a Health Planning Council, chaired by the Secretary of the Executive Office of Health and Human Services (EOHHS), to determine the medical needs of the Commonwealth. The Council will establish an advisory council of no more than 13 people. The Council must develop a State Health Plan, which will include an inventory of the current health care resources and make recommendations for the appropriate supply of such resources.
15	Health Policy Commission Chapter	Inserts Chapter 6D – Health Policy Commission (HPC)
15.01	HPC - Definitions	Definitions section for the HPC Chapter.
15.02	HPC - Structure	HPC will be an independent governmental agency under, but not subject to the control of, the Executive Office for Administration and Finance (A&F). HPC will be comprised of 13 commissioners. The Governor has the authority to appoint a chair who shall be an expert in the field. The commission by majority vote will appoint an executive director to supervise the administrative affairs and general management.
15.03	HPC - Board Powers	HPC will have the standard independent agency powers such as contracting, holding property and assets.
15.04	HPC - Advisory Council	The executive director is given the authority to appoint an advisory council to

Section #	Topic	Summary
		aid the commissioners.
15.05	HPC - Monitoring	HPC will be responsible for monitoring the transition away from fee-for-service reimbursements.
15.06	HPC - Funding Mechanism (Effective 7/1/2012 - §284)	HPC will be funded through an assessment on hospitals, ambulatory surgical centers and surcharge payors. The hospitals and ASCs will be responsible for at least 33% of the cost. Surcharge payors will also be responsible for at least 33%.
15.07	HPC - Healthcare Payment Reform Fund	HPC and the advisory council will be responsible for the administration of the Healthcare Payment Reform Fund as created and funded through the Casino Bill. The funds may be spent on incentives, grants or other assistance to providers for the purpose of fostering health care innovation in payment and delivery systems. HPC will coordinate the efforts of other similar funds such as the e-Health Institute Fund, Prevention and Wellness Trust Fund and the Distressed Hospital Fund.
15.08	HPC - Cost Trends Hearing	HPC, in consultation with CHIA, will hold annual cost trends hearings. CHIA will provide the data and information. This hearing is currently conducted by DHCFP.
15.09	HPC - Gross State Product Benchmark	HPC will set the annual Healthcare Cost Growth Benchmark (Benchmark). In 2013, the Benchmark is statutorily set at 3.6%. For calendar years 2014 - 2017, the Benchmark will be equal to the Growth Rate of Potential Gross State Product (GSP). For calendar years 2018 - 2022, the Benchmark will be equal to the growth rate of GSP minus 0.5%. HPC will have the authority to adjust the Benchmark to a number between minus 0.5% and 0%. The adjustment would require a two-thirds vote. Notice must be provided to the legislature who may take legislative action. In 2023 and beyond, the Benchmark will again be equal to GSP. HPC may make a recommendation to the legislature on any changes to the Benchmark. The recommendation could be adopted by HPC with a two-thirds vote. Notice must be provided to the legislature who may take legislative action.
15.10	HPC - Performance Improvement Plan	Beginning in 2016, Health Care Entities that exceed the Benchmark may be required by the Commission to submit a Performance Improvement Plan (PIP). The Commission will notify Health Care Entities that need file a PIP plan and

Section #	Topic	Summary
		give those entities 45 days to 1) file a plan or 2) ask for a time extension. The Commission may delay or waive the filing of a PIP based on the following factors: 1) Demonstrated improvement in cost reductions, 2) a health care entity's strategy or investments to improve future long-term efficiency, 3) whether the costs are controllable by the health care entity, 4) overall financial health of the entity, 5) difference between the projected and actual growth of GSP. A PIP must be implementable within 18 months. The Commission will approve PIPs. The Commission may fine a Health Care Entity up to $500,000 if the health care entity1) willfully neglects to file a PIP within 45 days, 2) fails to file a PIP in good faith, 3) fails to implement the PIP in good faith, or 4) fails to provide or falsifies information.
15.11	HPC - Registration of Provider Organizations	The Commission will develop the requirements for registering Provider Organizations. Provider Organizations must submit the following: 1) organizational charts including ownership, 2) number of health care employees and number of those affiliated or employed by the organization, 3) names and addresses of licensed facilities, and 4) other such information as the Commission deems appropriate.
15.12	HPC - Provider Organization Contracting Prohibition	Unregistered Provider Organizations are prohibited from entering into a network contract. Provider Organizations with fewer than 15,000 patients or collects less than $25 million in annual net patient revenues shall be exempt.
15.13	HPC - Market Impact Review (Effective 1/1/2013 - §283)	The Commission may conduct a Cost and Market Impact Review if 1) a provider or provider organization makes a material change in operations or governance structure, or 2) if a provider or provider organization exceeds the GSP Benchmark. The Commission must provide a written notice to the provider or provider organization, which has 21 days to reply. The Commission will gather information related to a provider or provider organization's costs, quality, market share, and financial health. The Commission will make a factual finding and present a preliminary report to the provider or provider organization, which in turn will be provided 30 days to respond to the report. After such period, the Commission will issue a final report.

Section #	Topic	Summary
15.14	HPC - Patient Centered Medical Homes	The Commission will develop standards for certification of Patient Centered Medical Homes (PCMH). The Commission will recognize medical homes that have been already given such a designation by the National Committee for Quality Assurance (NCQA). HPC will create a model payment for PCMHs. HPC will develop and distribute a referral directory of non-health care services such as housing, food, transportation, child care and other community-based services.
15.15	HPC – Accountable Care Organization	HPC will develop the rules for Accountable Care Organization (ACO) certification. A certified ACO must meet the following: 1) organized or registered as a separate entity from the ACO participants; 2) governance structure with an administrative officer, medical officer, and consumer representation; 3) ability to receive payment from alternative payment methodologies; 4) ability to coordinate such payments to its ACO participants; 5) undergo significant implementation of interoperable health information technology; 6) develop and file an internal appeals plan; 7) provide the continuum of care including behavioral and physical health; 8) implement systems to provide reporting of pricing amongst ACO participants; 9) obtain a risk certificate from DOI; and 10) engage patients in shared decision making. HPC will create a designation for Model ACOs for those that have demonstrated excellence by adopting best practices for quality improvement, cost containment and patient protections. ACOs are required to publish the standards they use to determine which providers of free-standing ancillary services will be approved to provide services to ACO patients. HPC will create a review process for aggrieved providers that are denied approval by an ACO as a provider of ancillary services.
15.16	HPC – Office of Patient Protection	The Office of Patient Protection (OPP) will be reconstituted within the HPC. OPP will have the following responsibilities: 1) administer and enforce the standards set forth in MGL c. 176O, §§13, 14, 15; 2) make managed care information collected by OPP available to the public; 3) assist consumers with questions and concerns about managed care; 4) monitor quality-related health insurance plan information; 5) regulate the establishment and functions of

Section #	Topic	Summary
		review panels under MGL c. 176O, §14; 6) periodically advise government including state agencies and the legislature; 7) administer and grant enrollment waivers related to open enrollment period for the merged market; and 8) establish rules and procedures related to appeals by consumers aggrieved by restrictions on patient choice, denials of care and quality of care by an ACO. HPC will create an external appeals process for the review of grievances of ACO patients.
15.17	Annual report to state auditor	HPC must submit an annual financial report to its board, the governor, the general court and the state auditor, the form of which is prescribed by the board and approved by the auditor. The state auditor is also empowered to conduct investigations and review properties and records of the HPC. The HPC is subject to biennial audits by the state auditor.
15.18	Regulations	Authorizes HPC to adopt regulations to implement chapter 6D
16	Technical Correction	Relative to DHCFP and CHIA.
17	Technical Correction	Relative to DHCFP and MassHealth.
18	Attorney General – Powers	The Attorney General's Office (AGO) will be responsible for monitoring trends in the healthcare marketplace. The AGO will be able to receive information submitted by the industry to CHIA; filings and documentation related to market impact reviews; filings and documents related to the Determination of Need process; and any filing or applications to CMS for demonstration projects. The AGO may investigate any health care entity for possible anti-competitive behavior referred by HPC.
19	CHIA Chapter	Inserts Chapter 12C - CHIA
19.01	CHIA – Definitions	Definitions Section for CHIA.
19.02	CHIA – Executive Director	CHIA will be run by an Executive Director. The Governor, Attorney General and Auditor by majority vote will appoint the director for a 5 year term. The Executive Director may serve up to 2 consecutive terms.
19.03	CHIA – Executive Director's Duties	The Executive Director can appoint officers, employees and establish subdivisions to perform the following duties: 1) collect, analyze and disseminate health care information to help form health care policy; 2) provide an analysis of

Section #	Topic	Summary
		health care spending trends to HPC; 3) collect, analyze and disseminate health care information to increase transparency; 4) work with the various branches of government to collect and disseminate information; 5) participate, provide data and provide analysis to HPC for its cost trends hearing; and 6) report to consumers the cost and quality of health care services through the consumer health information website.
19.04	CHIA – Compensation	Sets the compensation for the Executive Director and staff.
19.05	CHIA – Powers	CHIA is authorized to adopt and amend rules and regulations to administer its duties and powers to effectuate this chapter.
19.06	CHIA – Powers	CHIA is authorized to manage its own affairs, enter into contracts, acquire and own property in its name, and enter into any agreements with other governmental subdivisions.
19.07	CHIA – Funding/Assessment	Hospitals, Ambulatory Surgical Centers, and Surcharge Payors will be responsible for paying a portion of the estimated expenses of CHIA. Hospitals and Ambulatory Surgical Centers will be responsible for at least 33% of the cost. Surcharge Payors will also be responsible for at least 33% of the cost. Hospitals and Ambulatory Surgical Centers will pay half of their assessment by Oct 1 of each year.
19.08	CHIA – Data Collection	CHIA will promulgate regulations to ensure the uniform reporting of revenues, charges, costs, price and utilization of health care services. CHIA will require the reporting of discounts, rebates or any type of refund or remuneration for services provided by one provider to another. For hospitals, CHIA will establish regulations for the uniform reporting volume, case-mix and proportion of low-income patients. CHIA will analyze the following information from hospitals: 1) gross and net patient services revenues; 2) sources of hospital revenue; 3) private sector charges; 4) trends in inpatient and outpatient case mix, payer mix, volume and length of stay; 5) total payroll as a percentage of operation expense and a list of the top 10 compensated employees; and 6) relevant measures of financial health or distress. CHIA will generate an annual report on these hospital measures. CHIA will publicly report and place on its website, information on health status adjusted total medical expenses with breakdown by major service categories,

Section #	Topic	Summary
		relative prices and costs.
19.09	CHIA – Provider Organization Reporting	Providers Organizations are responsible for providing the following information annually: 1) organization chart of ownership, governance and operational structure; 2) number of affiliated health care professionals; 3) name and address of facilities; 4) comprehensive financial statements; 5) information on stop-loss insurance and any non-fee-for-service payments; 6) information on clinical quality, care coordination and patient referral practices; 7) information on expenditures and funding sources for payroll, teaching, research, advertising, and taxes or payments in lieu of taxes; 8) charitable care and community benefits; 9) risk bearing certificate if applicable; and 10) other information CHIA deems appropriate.
19.10	CHIA – Payer Reporting	CHIA will develop and maintain a database of health care claims data collected under this chapter. CHIA will specifically analyze the following: 1) changes of health insurance premiums over time; 2) changes in benefits and cost-sharing designs; 3) changes in measures of plan cost and utilization; and 4) changes in the types of payment methods used. Private Payers are required to submit the following information: 1) average annual individual and family plan premiums for each payer's most popular plan; 2) information on actuarial assumptions for setting premiums; 3) summaries of the plan and network design; 4) information on medical and administrative expenses, including medical loss ratios; 5) information on a payer's reserves and surpluses; 6) information on provider payment methods and levels; 7) health status adjusted total medical expenses by provider groupings; 8) relative prices by provider groupings; 9) hospital inpatient and outpatient costs including direct and indirect costs; 10) annual growth rate of average relative prices and as compared to the benchmark; and 11) a comparison of relative prices and identify those providers that are either above or below 10, 15, or 20 percent of the average relative price. Public Payers are required to submit the following information: 1) average premium rates for health insurance and their actuarial assumptions; 2) average per member per month (PMPM) payments for enrollees in the Primary Care Clinician and Fee For Service Programs; 3) summary of plan and network

Section #	Topic	Summary
		designs; 4) information concerning medical and administrative expenses, including medical loss ratios; 5) information concerning a payer's reserves and surpluses; 6) information on provider payment methods and levels, including payment levels for the top 25 most common medical procedures; 7) health status adjusted total medical expenses by provider grouping; 8) relative prices by provider grouping; 9) hospital inpatient and outpatient costs; 10) annual rate of growth for relative prices and as compared to the benchmark; and 11) a comparison of relative prices and identify those providers that are either above or below 10, 15, or 20 percent of the average relative price. Payers using alternative payment methodologies are required to submit the following: 1) the negotiated monthly or yearly budget for each alternative payment methodology contract; 2) measure of provider performance associated with each contract; and 3) the budget as weighted by member months and geography. All negotiated budgets must be reported based on a 1.0 health status score.
19.11	CHIA – Data Collection Fines	CHIA may assess a fine of $1,000 a week penalty up to $50,000 for any entity that fails to report information as required under sections 8, 9 and 10.
19.12	CHIA – All Payers Claims Database	CHIA will be responsible for creating an all payer and provider claims database, known as the All Payers Claims Database (APCD). Data will be made available to providers and payers in real-time. De-identified data will be available to providers, payers, government agencies and researchers for the purposes of lowering total medical expenses, coordinating care, benchmarking, quality analysis and other research or planning purposes. Patient-identified data will be made available to providers and payers for the purpose of treatment and care coordination.
19.13	CHIA – Uniform Licensure Reporting	CHIA will coordinate with the Public Health Council and the various boards of registration for health care professionals to develop a uniform and interoperable system for reporting licenses.
19.14	CHIA – Statewide Quality Advisory Committee	CHIA will develop a Standard Quality Measure Set and set regulations for the uniform reporting of quality measures by provider groups. In developing the Standard Quality Measure Set, CHIA will receive advice from an advisory committee, known as the Statewide Quality Advisory Committee (SQAC).

Section #	Topic	Summary
		SQAC must annually recommend to CHIA any updates to the standard quality measure set by November 1st.
19.15	CHIA – Betsy Lehman Center	The Betsy Lehman Center for Patient Safety and Medical Errors will be moved from DPH to CHIA. The Lehman Center is responsible for the following: 1) coordinating the efforts of state agencies to help providers reduce medical errors; 2) assisting those agencies as they work on patient safety; and 3) developing programs to include patients in improving safety. The Lehman center will analyze data and report information to improve training and education programs on patient safety. There will be a Patient Safety and Medical Errors Reduction Board to aid the Lehman Center in developing its regulations. The Lehman center will annually report to the Governor and Legislature about the feasibility of developing standards for patient safety and medical errors reduction. The Lehman Center will be responsible for the following: 1) identifying and disseminating information on evidence-based best practices on patient safety; 2) developing a process for determining the evidence-based best practices to adopt; 3) serving as the clearinghouse for collecting and analyzing information on the causes of medical errors; and 4) increasing awareness of error prevention strategies.
19.16	CHIA – Annual Report on Costs	30 days before the Cost Trends Hearing conducted by HPC, CHIA is responsible for issuing its annual report on the cost and cost trends of the industry and comparisons on the cost growth benchmark. The report will delve in the details of the following: 1) baseline information about cost, price, quality, utilization and market power; 2) cost growth trends for care provided within and outside an ACO and PCMHs; 3) cost growth trends by provider sectors; 4) factors that contribute to cost growth and their impact on premiums; 5) proportion of payments made through fee-for service and alternative payment methodologies; 6) impact of health care delivery and payment reform on cost containment; 7) impact of assessments on premiums; 8) trends in the utilization of duplicative or unnecessary services; 9) prevalence and trends in adopting alternative payment methodologies; 10) development and status of provider organizations; and 11) impact of health care delivery and payment reform on the quality of care.

Section #	Topic	Summary
		Additionally, the annual report will review price variation and include the following: 1) baseline information about price variation and the identity of providers that are paid more than 10% above the average price and providers paid more than 10% under the average price; 2) annual change in price variation; 3) factors that contribute to price variation; 4) impact of price variation in disproportionate share hospitals and safety net providers; and 5) the impact of health care delivery and payment reform on price variation. CHIA will attend the Cost Trends Hearings and provider technical support to HPC.
19.17	CHIA – AGO Powers	The AGO is given authority to review any information submitted to CHIA under sections 8, 9 and 10. The AGO may require any health care organization to provide additional documents, answer interrogatories or provide testimony under oath. All nonpublic information obtained under this section must be kept confidential and will be not considered a public record.
19.18	CHIA – Monitoring Benchmark	CHIA is responsible for continuous monitoring of the health care system to determine which entities have exceeded the benchmark and provide HPC with notice for potential action.
19.19	CHIA – Determination of Need	CHIA will review and comment on every capital expenditure that requires a Determination of Need by the Department of Public Health. CHIA will provide data and any necessary testimony.
19.20	CHIA – Consumer Website	Transfers the management of the current consumer health information website from QCC to CHIA. Expands upon the existing website to include more detailed comparative information on the cost and quality of health care services, including the contracted prices of services provided by facilities, providers, and provider organizations. Prices must be listed by payer. The website must also contain information showing how providers and payers are doing in relation to the statewide and regional benchmarks and growth goals. The bill also adds the following resources to the website: 1) the factors to consider when choosing an insurance product; 2) patient decision aids; 3) the definition of common health insurance and medical terms; and 4) a list of health care provider types and what types of services they are authorized to perform.

Section #	Topic	Summary
19.21	CHIA – Study on Uninsured and Underinsured	CHIA is responsible for creating a continuous program of study and investigation of the uninsured and underinsured in the Commonwealth.
19.22	CHIA – Audit Powers	CHIA is allowed to conduct audits on any provider that accepts payments for health care treatment under workman's compensation or payments from a governmental unit.
20	Technical Amendment	Relative to DHCFP & Commonwealth Connector Authority (Connector).
21	Technical Amendment	Relative to DHCFP & CHIA.
22	Technical Amendment	Relative to DHCFP & MassHealth.
23	Mental Health Parity	Empowers the Commission of Insurance to enforce state and federal mental health parity laws.
24	Technical Amendment	Relative to DHCFP & Connector.
25	Technical Amendment	Relative to DHCFP.
26	Technical Amendment	Relative to DHCFP & MassHealth.
27	Technical Amendment	Relative to DHCFP.
28	Health Care Workforce Transformation Fund	Creates a Health Care Workforce Transformation Fund to be administered by the Secretary of Labor and Workforce Development. Establishes a 13 member advisory board to the Secretary regarding administration and allocation of funds. A minimum of 20% of the fund must be spent on the Health Care Workforce Loan Repayment Program, Primary Care Residency Grant Program and a Primary Care Workforce Development and Loan Forgiveness Grant Program at Community Health Centers. Under subsection (d), remaining monies may be spent on the following: 1) support programs to improve retention rates on health care workers; 2) address critical shortages in the health care workforce; 3) improve health care job opportunities for low-income and low-wage individuals; 4) provide training, educational and career ladder services for health care workers seeking new positions; 5) provide training and educational services for health care workers in emerging fields of care delivery; or 6) fund rural health rotation programs at medical and nursing schools The Secretary will establish a competitive grant program for the programs under subsection (d).

Section #	Topic	Summary
29	Distressed Hospital Trust Fund	There will be a Distressed Hospital Trust Fund under the control of HPC. All expenditures must have 1 or more of the following purposes: 1) improve the ability of community hospitals to serve populations efficiently and effectively; 2) advance the adoption of Health Information Technology (HIT) and interoperability; 3) accelerate the ability to exchange health information electronically; 4) support transitions toward alternative payment methodologies; 5) aid the development of operational standards necessary for certification as an ACO; and 6) improve the affordability and quality of care. The Commission will annually award grants through a competitive grant process to qualified acute hospitals. Expenditures may not be made to 1) teaching hospitals, 2) hospitals with a relative price above the statewide average, and 3) for-profit hospitals or hospitals owned by for-profit companies.
30	Setting Potential GSP	On or before Jan. 15th each year, the Secretary of A&F and the committees on Ways and Means will develop a Growth Rate of Potential GSP. Growth Rate of Potential GSP is the long-run average growth rate of the Commonwealth's economy, excluding fluctuations due to the business cycle.
31	Technical Amendment	Relative to DHCFP and MassHealth.
32	Technical Amendment	Relative to DHCFP and MassHealth.
33	Technical Amendment	Relative to DHCFP and MassHealth.
34	Primary Care Provider	Adds the definition of a Primary Care Provider into chapter 32A
35	Primary Care Provider	Changes the word "primary care physician" to "primary care provider" in statute requiring the Group Insurance Commission to cover mental health services for non-biologically based mental disorders in children if the child was diagnosed by a primary care provider.
36	Transparency – Group Insurance Commission Consumers (Effective 10/1/2013 - §295)	Directs the Group Insurance Commission (GIC) or its third-party administrators to establish a toll-free number and website that enables consumers to obtain from the carrier, within 2 working days, the allowed amount or charge for a proposed service and the estimated amount the consumer will be expected to pay out-of-pocket. Consumers are protected from paying more than the disclosed amount.
37	Transparency – GIC Consumers	Amends the previous section from 2 business days to real time access to

Section #	Topic	Summary
	(Effective 10/1/2013 - §296)	information.
38.6D	Massachusetts e-Health Institute	Amends the Massachusetts e-Health Institute (MeHI) within the Massachusetts Technology Collaborative (MTC). The institute will be responsible for 1) operating the Regional Extension Center (REC) and coordinating and implementing HIT; 2) fulfilling its current and future contract obligations related to the MassHealth electronic health records incentive program; and 3) developing a plan for the implementation of HIT. MeHI will work with the HIT Council to advance the use of interoperable HIT by: 1) facilitating the implementation and use of interoperable HIT by providers; 2) supporting the HIT Council as it develops the statewide Health Information Exchange (HIE); 3) identifying and promoting the use of emerging technologies; 4) helping providers to achieve and maintain meaningful use; and 5) promoting the benefits of HIT to consumers and providers. MeHI is responsible for issuing an Electronic Health Records Plan. The plan should be updated from time to time to reflect changes in technology. The update plan should include: 1) provisions to allow seamless, secure electronic exchange of information; 2) provide consumers with access to their own health information; 3) meet all federal and state privacy and security requirements; 4) meet standards for interoperability; 5) give consumers the ability to provide their health information to only certain designated health care providers; 6) provide public health reporting capability; 7) support activities of the Healthcare Payment Reform Fund, and 8) allow reporting of health information other than patient-identifiable data to EOHHS. MTC is allowed to contract with implementing organizations for the following: 1) facilitate the public-private partnership in HIT; 2) provider resources and support for grant recipients; 3) certify and disburse funds to subcontractors; 4) provide technical assistance to providers that adopt HIT; 5) ensure HIT that is both interoperable and secure; and 6) certify subcontractors who will provide hardware and software for system implementation. MeHI will establish a pilot partnership with community colleges and vocational technology schools to support a HIT curriculum. MeHI will encourage the implementation of evidence-based clinical decision

Section #	Topic	Summary
		support tools for advanced diagnostic imaging services.
38.6E	HIT - e-Health Institute Fund	This section creates the e-Health Institute Fund to support the work of the e-Health Institute. The funds may not be used for federal match on programs that this fund does not cover.
39	HIT – Revolving Loan Fund	This section creates the Massachusetts Health Information Technology Revolving Loan Fund. The purpose of the fund is to provide money for interest free loans to providers for implementing interoperable HIT systems. MeHI will make loans available through the use of private banks. It will work with the state treasurer to develop a lender partnership program that requires the following: 1) banks that are adequately capitalized; 2) MeHI will create the lending standards such as eligibility, size and number of loans; and 3) that all loans are interested free. Banks participating in this program may receive reasonable application and administrative fees. Providers, at a minimum, must provide the following information for a loan: 1) amount of the loan requested and a description of the project; 2) price quote from a vendor; 3) a description of the provider or group seeking the loan; 4) financial condition and ability to repay; and 5) description of how the funds will be used to meet federal and state interoperability standards. Loans must be repaid within 5 years.
40	Technical Amendments	Repealed sections that were moved to 118I.
41	Wellness – Tax Credit (Effective 1/1/2013 - §297)	Creates a tax credit for businesses that implement a wellness program. Businesses will receive a credit of 25% of the implementation cost up to a credit of $10,000. The tax credit may carry over, but must be taken within 5 years. The credit may not be used reduce a business's tax liability below zero.
41A	Wellness – Tax Credit Repeal (Effective 12/31/2017 - § 298)	The Wellness Tax Credit in section 41 is repealed.
43	Technical Amendment	Relative to DHCFP and EOHHS.
44	Technical Amendment	Relative to DHCFP and MassHealth.
45	Technical Amendment	Relative to DHCFP and EOHHS.
46	Technical Amendment	Relative to DHCFP and MassHealth.
47	Technical Amendment	Relative to DHCFP and MassHealth.
48	Technical Amendment	Relative to DHCFP and MassHealth.

Section #	Topic	Summary
49	Technical Amendment	Relative to DHCFP and MassHealth.
50	Technical Amendment	Relative to DHCFP.
51	Technical Amendment	Relative to DHCFP and MassHealth.
52	Technical Amendment	Relative to DHCFP and MassHealth.
53	Technical Amendment	Relative to DHCFP and EOHHS.
54	Technical Amendment	Relative to DHCFP and EOHHS.
55	Technical Amendment	Relative to DHCFP, MassHealth and Connector.
56	Wellness – Tax Credit (Effective 1/1/2013 - §297)	Creates a tax credit for businesses that implement a wellness program. Business will receive a credit of 25% of the implementation cost up to a credit of $10,000. The tax credit may carry over, but must be taken within 5 years. The credit may not be used reduce a business's tax liability below zero.
56A	Wellness – Tax Credit Repeal (Effective 12/31/2017 - § 298)	The Wellness Tax Credit in section 56 is repealed.
57	Technical Amendment	Relative to DHCFP and MassHealth.
58	Technical Amendment	Relative to DHCFP and MassHealth.
59	Public Health Definition – Primary Care Provider	Adds the definition of a primary care provider to Chapter 111.
60.2G	Prevention and Wellness Trust Fund	Creates the Prevention and Wellness Trust Fund, to be administered by the Commissioner of Public Health in consultation with the Prevention and Wellness Advisory Board. All expenditures from the fund will support the efforts of meeting the cost growth benchmark and one or more of the following: 1) reduce rates of the most prevalent and preventable conditions including substance abuse; 2) increase healthy behaviors; 3) increase the adoption of workplace wellness programs; 4) address health disparities; and 5) develop stronger evidence-based prevention programs. Grants will be available to 1) municipalities or groups of municipalities; 2) community-based organizations working with municipalities; 3) health providers or health plans working with community-based organizations or municipalities; or 4) regional planning agencies. The Commissioner may not spend more than 10% of the fund on promoting workplace wellness programs. The funds may be expended on the following: 1)

Section #	Topic	Summary
		developing and distributing information tool-kits to employers including model guides; 2) providing technical assistance to employers implementing wellness programs; 3) hosting information forums for employers; 4) promoting awareness of the tax credit and the wellness subsidies offered by the Connector; 5) public information campaigns that quantify the importance of healthy lifestyles; and 6) providing grants for employers that implement and administer workplace programs up to 50% of the cost as combined with any potential tax credits. DPH will provide an annual report on the operation of the fund. DPH will annually report on its strategy for using the funds, which will include 1) a list of the most prevalent preventable health conditions; 2) a list of the most costly preventable health conditions; and 3) a list of evidence-based or promising programs that combat those health conditions; and 4) a list of evidence-based workplace wellness programs or health management programs to combat those health conditions.
60.2H	Prevention and Wellness Advisory Committee	Creates a 17 person advisory board, to be chaired by the Commission of Public Health, to make recommendations to the Commissioner concerning the administration and allocation of Prevention and Wellness Trust Fund.
61	Technical Amendment	Relative to DHCFP and EOHHS.
62	Technical Amendment	Relative to DHCFP and MassHealth.
63	Technical Amendment	Relative to Determination of Need (DON).
64	Technical Amendment	Relative to DON.
65	Technical Amendment	Relative to DON.
66	Technical Amendment	Relative to DON.
67	DON – Definition	Clarifies the definition of services within an Ambulatory Surgical Center to include those performed either in a clinic licensed through section 51 or a clinic within a hospital.
68	DON – Definition	Amends the definition of Innovative Services by modernizing from an enumerated list to a flexible list.
69	DON – Definition	Amends the definition of New Technology by modernizing from an enumerated list of a flexible list.
70	DON – Definition	Technical change to correct grammar.
71	DON – Determination of Need	Requires a project subjected to a DON to submit the information to CHIA and

Section #	Topic	Summary
		HPC in addition to filing with DPH. Implements a new fine of up to 3 times the project cost for providers that violate this section. Increases the DON threshold for innovative services or new technologies from $150,000 to $250,000. Maintenance or replacement of new technology does not require a new DON review. Any DON review requires a review of the State Health Plan. The Attorney General is allowed to request a public hearing on any DON and may intervene in any DON public hearing. DPH may require the applicant to provide an independent cost analysis. Provides new language allowing other specialized departments to receive applications for service providers covering those specialized service.
72.25L	Workforce Development – Workforce Center	Amends the current Health Care Workforce Center responsibilities to address physician assistants and behavioral and mental health providers in any workforce development activities undertaken by the Center.
72.25M	Workforce Development – Workforce Advisory Council	Amends the current Workforce Advisory Council by requiring it to review the use of services by physician assistants and behavioral and mental health providers. Expands the Health Care Workforce Advisory from 16 members to 19 members by including a member from the Massachusetts Association of Physician Assistants, a member of the Massachusetts Chiropractic Society, and a behavioral, substance abuse disorder and mental health professional.
72.25N	Workforce Development – Workforce Loan Repayment Program	Amends the current Workforce Loan Repayment Program to include physician assistants and behavioral and mental health professionals as eligible recipients of loan repayment funds.
72.25N½	Workforce Development – Community Health Center Residency Grant Program	Establishes a residency grant program to finance the training of primary care providers at community health centers (CHCs). To be eligible for funds, applicant CHCs must demonstrate that at least 50% of their graduates practice in primary care within 2 years of graduation. Funds for this program will come from the Health Care Workforce Transformation Fund.
72.25N¾	Workforce Development – CHC Loan Repayment Programs	Establishes a Primary Care Workforce Development and Loan Forgiveness Program at CHCs to improve recruitment and retention of primary care providers. DPH is responsible for administering the Grant Program.
73	Technical Amendment	Relative to DPH.
74	Technical Amendment	Relative to DHCFP and EOHHS.

Section #	Topic	Summary
75	Technical Amendment	Relative DHCFP and CHIA.
76	Technical Amendment	Relative to DHCFP.
77	DPH – Essential Services	Requires DPH to conduct a public hearing on any proposed closure of essential health services or hospital.
78	DPH – Essential Services	Requires hospitals that close essential services provide a plan to aid patients in receiving those services.
79	Technical Amendment	Relative to the QCC and CHIA.
80.51I	Checklists of Care	DPH will encourage the use of checklists of care to prevent adverse events and reduce healthcare-associated infections. DPH will develop a model checklist as an example for facilities to adopt. Facilities will be required to report if they have adopted a checklist or not.
80.51J	Limited Service Clinics	Allows limited service clinics to provide care within the scope of a nurse practitioner. However, a limited service clinic cannot act as the patient's primary care provider.
81	Limited Service Clinics – Definitions	Adds the definitions of "limited services" and "limited service clinic" to Chapter 111.
82	Malpractice Contracting	Prohibits hospitals from entering into contracts with physicians that prohibit the physician from providing testimony in an administrative or judicial hearing.
83	Technical Amendment	Relative to DHCFP and EOHHS.
84	Technical Amendment	Relative to DHCFP and EOHHS.
85	Primary Care Provider	Changes of the word "primary care physician" to "primary care provider" in statute ensuring that newborn hearing screening tests are returned to the primary care provider.
86	Technical Amendment	Relative to DHCFP and EOHHS.
87	Nursing Homes – Change of Room	Allows a nursing home to move patients within the facility as the needs of the patient changes such as needing or ceasing to need specialized accommodations, care, services, technology or staffing.
88	Technical Amendment	Relative to DHCFP and CHIA.
89	Technical Amendment	Relative to DHCFP and CHIA.
90	Technical Amendment	Relative to DHCFP and MassHealth.
91	Technical Amendment	Relative to DHCFP and EOHHS.

Section #	Topic	Summary
92	Technical Amendment	Relative to DHCFP and EOHHS.
93	Technical Amendment	Relative to DHCFP and EOHHS.
94	Technical Amendment	Relative to DHCFP and EOHHS.
95	Technical Amendment	Relative to DHCFP and EOHHS.
96	Technical Amendment	Relative to DHCFP and EOHHS.
97	Technical Amendment	Relative to DHCFP and EOHHS.
98	Technical Amendment	Relative to DHCFP and EOHHS.
99	Technical Amendment	Relative to DHCFP and EOHHS.
100	Wellness Seal of Approval	DPH will be responsible for implementing a seal of approval process of workplace wellness programs. In developing criteria for a seal of approval, the department will consider the following factors: 1) whether the wellness program is actuarially equivalent to the connector's wellness programs; 2) whether the program provides new or innovative services; 3) the employee participation rate; 4) quality of health education being provided; and 5) whether the program promotes a healthy workplace.
101	Technical Amendment	Relative to DHCFP.
102	Technical Amendment	Relative to DHCFP and CHIA.
103.225	Clinical Laboratory Payments	Clinical labs or physicians providing anatomic pathology services may only seek payment from 1) patients; 2) insurance carriers; 3) hospitals or clinics; 4) the referral lab or physician performing anatomic pathology services; or 5) government agency providing health coverage to a patient. Except as provided in this section, a provider may not seek reimbursement for the services performed by the clinical lab or another physician.
103.226	Mandatory Overtime for Nurses	A hospital may not require a nurse to work mandatory overtime hours unless in case of emergency. It will be considered an emergency when patient safety requires the staffing and there is no reasonable alternative. HPC will develop guidelines and procedures to further define an emergency. Hospitals are required to issue reports on its usage of mandatory overtime. Nurses are prohibited from working more than 16 hours in a 24 hour period and any nurse working 16 consecutive hours must be given at least 8 hours of off time immediately following the end of said 16 hour shift.

Section #	Topic	Summary
103.227	Decision Making – Palliative Care and End-of-Life Options	DPH will regulate the distribution of information on palliative care and end-of-life options to appropriate patients in health care facilities. Patients diagnosed with terminal illness or conditions should receive the following: 1) range of options appropriate for the patient; 2) prognosis, risks and benefits of options; 3) patients' legal rights to comprehensive pain and symptom management. Providers must provide this counseling to an incapacitated patient's representative. This section is not be construed as allowing or promoting assisted suicide or prescribing of medication to end life.
103.228	Transparency (Effective 1/1/2014 - §285)	Requires a Health Care Provider to disclose the allowed amount or charge to a patient within 2 business days. The provider may provide maximum estimated allowed amounts or charges if it does not provide the actual estimate. A provider that refers a patient to a provider in the same provider organization must give a disclosure of that relationship.
104	Technical Amendment	Relative to DHCFP.
105	Technical Amendment	Relative to DHFCP and CHIA.
106	Technical Amendment	Relative to DHCFP and CHIA.
107	Technical Amendment	Relative to DHCFP and CHIA.
108	HIT – Meaningful Use (Effective 1/1/2015 - §299)	Amends the physician HIT proficiency requirement to require that physicians are trained to use HIT systems that meet meaningful use criteria.
109	Medical Malpractice – Contract Prohibitions	Prohibits a physician from entering into any contract or agreement that prevents the doctor from testifying in an administrative or judicial hearing.
110	Definitions – Physician Assistant	Amends the definition of Physician Assistant within Chapter 112.
111	Physician Assistants – Cap	Removes the cap on the number of Physician Assistants that a physician may supervise.
112	Physician Assistants - Prescriptions	Removes a requirement that all prescriptions written by a Physician Assistant includes the name of the supervising physician.
113	Nurse Practitioners	Allows Nurse Practitioners to sign, certify, stamp, verify or endorse any documents related to physical and mental health that a physician would sign, certify, etc.
114	Definitions – Primary Care Provider	Adds the definition of primary care provider to chapter 118E.

Section #	Topic	Summary
115	Definitions – MassHealth	Moves definitions from DHCFP, Chapter 118G, to Chapter 118E for all the programs and duties shifting from DHCFP to EOHHS and MassHealth.
116	Technical change	Eliminates reference to repealed statute.
117	MassHealth - Dual Eligibles	Adds a new section 9F to chapter 118E requiring that members of the MassHealth dual eligible pilot program be provided with an independent community care coordinator. The ICO is to participate in health and functional status assessments of members, arrange for and coordinate appropriate institutional and community long-term supports and services and monitor the provision and outcomes of community long-term care services.
118	Technical change	Reflects change from DHCFP to CHIA.
119	Technical change	Reflects change from DHCFP to EOHHS.
120	Technical change	Reflects change from DHCFP to EOHHS.
121	Technical change	Reflects change from DHCFP to CHIA.
122	Technical change	Removes reference to QCC (eliminated by section 7).
123		Adds 10 sections to chapter 118E. These sections are all from existing law in chapter 118G and reflect the elimination of DHCFP and the move of these provisions to EOHHS.
123.13C	EOHHS rate setting	Provides for establishment of rates for health care services by the HHS secretary. Moved from section 2A of chapter 118G.
123.13D	EOHHS-Determination of rates of payment	Provides for determination by HHS secretary or designated governmental unit of rates to be paid to institutional and non-institutional providers for health care services and social programs and rates to be charged by state institutions for general health supplies, care or rehabilitative services and accommodations. Moved from section 7 of chapter 118G.
123.13E	EOHHS-Appeal from final or interim rate	Provides for appeals by aggrieved parties of interim or final rates established by EOHHS. Moved from section 9 of chapter 118G.
123.13E ½	EOHHS-Contracts for services with acute and non-acute hospitals	Authorizes purchasers and third party payers (excepting workers' comp.) to enter into contracts with acute and non-acute hospitals for services. Moved from section 10 of chapter 118G.
123.13F	EOHHS-Rates of payment under Title XIX	Provides that rates of payment to acute and non-acute hospitals under the Medicaid program shall be established by contract between the provider of

Section #	Topic	Summary
		hospital services and the office of Medicaid. Separate rate-setting requirements apply to disproportionate share hospitals providing care to medical assistance recipients and emergency services and care provided to medical assistance recipients. Moved from section 11 of 118G.
123.13G	EOHHS-Excluded sources of revenue	Provides for the exclusion of certain sources of revenue from consideration in establishing, reviewing or approving hospital rates and charges. Moved from section 12 of chapter 118G.
123.13H	Access to care for chapter 117A recipients	Provides no acute hospital shall deny access to care that the hospital would provide under chapter 118E to those receiving benefits under chapter 117A of the General Laws (emergency aid program for elderly and disabled residents). Moved from section 13 of chapter 118G.
123.13I	Surcharges for residents of other countries	Exempts all costs and charges for patients who are residents of other countries from the limitations imposed by chapter 118E and allows hospitals to impose surcharges on normal charges that would otherwise be allowed for such foreign residents. Moved from section 14 of chapter 118G.
123.13J	Contracting rights of HMOs	Governs rights of HMOs to negotiate contract rates with hospitals. Moved from section 15 chapter 118G.
123.13K	Adjustment of rates upon a petition of receiver	Provides for adjustment of a facility's rate if needed to ensure compensation of a receiver and payment of a bond.
124	Technical change	Reflects change from DHCFP to EOHHS.
125	Emergency services-Medicaid recipients	Changes primary care physician to primary care provider in provider relative to emergency services provided to a medical assistance recipient.
126	Technical change	Changes section reference to reflect move of Health Safety Net from DHCFP to the office of Medicaid.
127	Technical change	Changes chapter references to reflect change from DHCFP to EOHHS.
128	Technical change	Changes references to reflect change from DHCFP to EOHHS.
129	Technical changes	Changes references to reflect move of section from DHCFP chapter to EOHHS.
130	Technical change	Changes references to reflect move of section from DHCFP chapter to EOHHS.
131		Adds 15 sections to chapter 118E.
131.63	Nursing home assessments	Moves nursing home assessments from DHCFP to EOHHS. Moved from section 25 of chapter 118G.

Section #	Topic	Summary
131.64	Definitions applicable to sections 64-69 of chapter 118E-Health Safety Net	Contains definitions applicable to Health Safety Net office provisions (moved to chapter 118E from chapter 118G).
131.65	Health Safety Net office	Establishes Health Safety Net (HSN) office within the office of Medicaid. Moved from DHCFP. Formerly in section 35 of chapter 118G.
131.66	Health Safety Net Trust Fund	Establishes Health Safety Net Trust Fund (HSN Trust Fund) under the administration of the office of Medicaid. Formerly administered by HSN Office of DHCFP. Formerly in section 36 of chapter 118G.
131.67	Liability of Acute Hospitals to HSNTF	Provides for calculation of acute hospitals' liability to the HSN Trust Fund. Formerly in section 37 of chapter 118G.
131.68	Acute Hospital and Ambulatory Surgical Center Surcharge	Provides for assessment of surcharges on payments by a payer to acute hospitals and ambulatory surgical centers. Formerly in section 38 of chapter 118G.
131.69	Reimbursements for health services provided to the uninsured and underinsured	Governs procedures for reimbursements from the HSN Trust Fund for health services provided to the uninsured and underinsured. Formerly in section 39 of chapter 118G.
131.70	Definitions applicable to Personal Care Attendant quality home care workforce council provisions	Sets forth definitions applicable to sections 70 through 75 of chapter 118E relative to the Personal Care Attendant (PCA) quality home care workforce council.
131.71	PCA quality home care workforce council-establishment	Establishes a 9-member PCA quality home care workforce council within EOHHS but not subject to its control. The council is to ensure the quality of long-term in-home personal care by recruiting, training and stabilizing the PCA workforce. Members appointed by the governor, auditor and attorney general.
131.72	Duties of the PCA quality home care workforce council	Specifies the duties of the council including to undertake recruiting efforts, provide training opportunities, assist consumers in finding PCAs by establishing a referral directory and provide referrals of PCAs. Preference to be given to public assistance recipients and other low-income persons who would qualify for assistance absent such employment.
131.73	Consumers' rights relative to PCAs; Status as public employees; Collective bargaining	Provides that consumers have the right to select, hire, train direct, supervise and terminate PCAs and may select PCAs not referred by the council. Provides that PCAs are considered public employees for the purposes of collective bargaining statutes (chapter 150E) and statutes relative to deductions for certain benefits and dues under chapter 180 but are not deemed to be public employees for any

Section #	Topic	Summary
		other purpose. Includes other provisions relative to collective bargaining and prohibits strikes or other similar labor actions.
131.74	Contracting authority of PCA quality home care workforce council	Authorizes the council to enter into contract in the performance of its duties. The council may provide, for a fee, recruitment, training and referral services to PCA and consumers other than those defined in statute. Specifies other powers of the council.
131.75	Biennial performance review by council	Requires the council to conduct a performance review every two years and submit a report of the review to the governor and legislature, which must be made publicly available. The review is to include an evaluation of the health, welfare and satisfaction with services on the part of those receiving long-term in-home PCA services, an explanation of the cost of PCA services and recommendations to the governor and legislature for any amendments to the PCA statutes.
131.76	Delegation of functions of EOHHS	Authorizes the HHS secretary to designate another governmental unit or units to perform rate setting, contracting and other functions under sections 13C to 13K and Health Safety Net and PCA council functions under sections 64 through 75.
131.77	Office of Medicaid-attribution of members to a PCP	Provides that the office of Medicaid, to the maximum extent possible, shall attribute every member to a primary care provider.
132	DHCFP-Repeal	Repeals chapter 118G relative to health care policy and finance and eliminates DHCFP.
133	Commonwealth Care-attribution of members to a PCP	Provides that Commonwealth Care, to the maximum extent possible, shall attribute every member to a primary care provider.
134	Health Information technology	Adds chapter 118I relative to health information technology.
134.1	Definitions applicable to chapter 118I	Contains definitions of terms used in chapter 118I.
134.2	Health Information Technology Council	Establishes a 21 member health information technology council (HITC) within EOHHS to advise EOHHS on design, implementation, operation and use of the statewide health information exchange (HIE) and related infrastructure.
134.3	EOHHS-Contracts and HIT plan	Authorizes EOHHS to conduct procurements and contract for purchase and development of hardware and software in establishing the HIE. EOHHS to oversee, in consultation with HITC, the technical aspects of developing and implementing the HIE. Requires EOHHS to develop, in consultation with the

Section #	Topic	Summary
		HITC, an HIE strategic and operating plan, to implement, operate and maintain the HIE, to develop and implement HIE infrastructure and to manage the Office of the National Coordinator (ONC)-HIE Cooperative Agreement and ONC Challenge Grant programs.
134.4	HITC and EOHHS – HIE policies	Requires the HITC to consult organizations of regional payers and providers in developing the HIE and EOHHS to adopt policies that are consistent with those adopted by the ONC but which may go beyond the ONC policies.
134.5	HITC-approval of expenditures and HIE implementation plan	Provides that the HITC must approve expenditures from the Massachusetts Health Information Exchange Fund. Requires the HITC to annually prepare and update a statewide HIE implementation plan. Specifies requirements applicable to the plan.
134.6	Patient access to electronic health record (Effective 1/1/2017 - §287)	Requires that patients have electronic access to their own health records. Requires that the HIE include the ability to transmit electronic copies directly to patients or allow facilities to provide mechanisms for patients to access their own electronic health record.
134.7	Electronic Health Record Implementation (Effective 1/1/2017 - §286)	Requires that all providers in the state implement interoperable electronic health records system that connect to the statewide HIE.
134.8	Penalties	Provides that EOHHS prescribe by regulation penalties for non-compliance by healthcare providers with electronic health record implementation requirements under section 7. EOHHS may waive penalties for good cause. Penalties also subject to waiver on grounds of lack of broadband access as provided in section 9.
134.9	Waivers – Absence of Broadband Access	Provides that providers who lack broadband access in their geographic area may apply to EOHHS for a waiver of the electronic health records requirements of section 7 or other HIT requirements implemented by EOHHS.
134.10	Massachusetts Health Information Exchange Fund	Establishes the Massachusetts Health Information Exchange Fund for the purpose of developing the statewide HIE.
134.11	HIT plan requirements	Establishes requirements for HIT plans approved by the HITC/EOHHS (health information exchange) and the e-Health Institute (provider electronic health records). Plans must establish a mechanism for patients to opt-in and opt-out of the HIE, maintain individually identifiable health information in physically and

Section #	Topic	Summary
		technologically secure environments, afford patients the option of obtaining a list of those who have accessed their records, develop and distribute to authorized HIE users written privacy, confidentiality and security guidelines and inform patients of by whom and how their information may be accessed, and ensure compliance with state and federal privacy requirements.
134.12	Procedures upon unauthorized access to patient information	Sets forth procedures to be followed in the event that individually identifiable patient health information is disclosed or accessed without authorization.
134.13	Provider access to patient records	Provides that the ability of a provider to transfer or access patient electronic health records is subject to a patient's election to participate in the electronic health information exchange under section 11.
134.14	Federal Financial Participation	Requires EOHHS, the HITC and the e-Health Institute to pursue and maximize opportunities to qualify for federal funding under the HITECH act. Provides that HITC shall consult with the office of Medicaid to qualify expenditures for any other federal financial participation programs.
134.15	HITC annual report	Requires the HITC to file an annual report describing the progress of HIE implementation and recommending any appropriate further legislative action.
134.16	Penalties for unauthorized disclosure or access to patient records	Provides that unauthorized access to or disclosure of individually identifiable patient information shall be subject to fines and penalties as determined by EOHHS.
135	Technical Change	Amends Tewksbury Hospital statute to change DHCFP to EOHHS in reference to certain assessments.
136	Technical Amendment	Relative to DHCFP and EOHHS.
137	Technical Amendment	Relative to DHCFP and EOHHS.
138	Technical Amendment	Relative to DHCFP and EOHHS.
139	Technical Amendment	Relative to DHCFP and EOHHS.
140	Technical Amendment	Relative to DHCFP and Connector.
141	Fair Share Employer Contribution – FTE Threshold (Effective 7/1/2013 - §301)	Raises the full-time equivalent (FTE) threshold under which an employer is subject to the Fair Share Employer Contribution from 11 FTEs to 21 FTEs.
142	Fair Share Employer Contribution – Employees with Other Insurance	Excludes employees who have qualifying health insurance coverage from a spouse, parent, veteran's plan, Medicare, or a plan due to disability or retirement

Section #	Topic	Summary
	(Effective 7/1/2013 - §301)	when determining whether an employer is a contributing employer.
143	Technical Amendment	Relative to DHCFP and MassHealth.
144	Technical Amendment	Relative to DHCFP and MassHealth.
145	Technical Amendment	Relative to DHCFP and Connector.
146	Technical Amendment	Relative to DHCFP and EOHHS.
147	Technical Amendment	Relative to DHCFP and EOHHS.
148	Technical Amendment	Relative to DHCFP and MassHealth.
149	Technical Amendment	Relative to DHCFP and MassHealth.
150	Insurance- Definition	Adds the definition of "primary care provider" under the insurance General Law.
151	No section 151	--
152	Primary Care Providers	Changes the word "primary care physician" to "primary care provider" in statute requiring insurers to cover mental health services for non-biologically based mental disorders in children if the child was diagnosed by a primary care provider.
153	Primary Care Providers	Changes the word "primary care physician" to "primary care provider" in statute permitting insurance carriers to require a member to alert their primary care provider if they received emergency care.
154	Wellness Program- Premium Rate Adjustment	Requires insurance policies to include a premium rate adjustment based on an employee's participation in a qualified wellness program. The Division of Insurance will determine the criteria for a qualified wellness program to determine eligibility for the rate discount.
155.108L	Primary Care Attribution - Insurers	Requires insurers to attribute every member to a primary care provider.
155.108M	Transparency- Patient-level Data and Prices (Effective 10/1/2013 - §288)	Requires insurers to A) disclose patient-level data to providers in their network for the purpose of carrying out treatment, coordinating care, and managing the care of their patients; and B) disclose the contracted prices of health services to providers who are under alternative payment contracts, for the purpose of referrals.
156	No section 156	--
157	No section 157	--
158	Telemedicine	Permits insurers to limit coverage of telemedicine services to those health

Section #	Topic	Summary
		providers in a telemedicine network approved by the insurer. Permits insurers to charge a deductible, copayment or coinsurance for telemedicine services provided that such charges do not exceed that of an in-person consultation.
159	Technical Amendment	Relative to DHCFP and EOHHS.
160	Primary Care Provider	Changes the word "primary care physician" to "primary care provider" in statute requiring Blue Cross Blue Shield to cover mental health services for non-biologically based mental disorders in children if the child was diagnosed by a primary care provider.
161	Primary Care Provider	Adds the definition of "primary care provider" under General Law pertaining to Blue Cross Blue Shield.
162	Blue Cross Blue Shield- Definitions	Adds the definition of "primary care provider" under General Law pertaining to Blue Cross Blue Shield.
163	Primary Care Provider	Changes the word "primary care physician" to "primary care provider" in statute permitting Blue Cross Blue Shield to require a member to alert their primary care provider if they received emergency care.
164	Technical Amendment	Relative to DHCFP and CHIA.
165.36	Primary Care Attribution -BCBS	Requires Blue Cross Blue Shield to attribute every member to a primary care provider.
165.37	Transparency- Patient-level Data and Prices (Effective 10/1/2013 - §289)	Requires Blue Cross Blue Shield to A) disclose patient-level data to providers in their network for the purpose of carrying out treatment, coordinating care, and managing the care of their patients; and B) disclose the contracted prices of health services to providers who are under alternative payment contracts, for the purpose of referrals.
166	Blue Cross Blue Shield- Definitions	Adds the definition of "primary care provider" under General Laws pertaining to Blue Cross Blue Shield.
167	Primary Care Providers	Changes the word "primary care physician" to "primary care provider" in statute requiring Blue Cross Blue Shield to cover mental health services for non-biologically based mental disorders in children if the child was diagnosed by a primary care provider.
168	Primary Care Providers	Changes the word "primary care physician" to "primary care provider" in statute permitting Blue Cross Blue Shield to require a member to alert their primary care provider if they received emergency care.

Section #	Topic	Summary
169.23	Primary Care Attribution -BCBS	Requires Blue Cross Blue Shield to attribute every member to a primary care provider.
169.24	Transparency- Patient-level Data and Prices (Effective 10/1/2013 - §290)	Requires Blue Cross Blue Shield to A) disclose patient-level data to providers in their network for the purpose of carrying out treatment, coordinating care, and managing the care of their patients; and B) disclose the contracted prices of health services to providers who are under alternative payment contracts, for the purpose of referrals.
170	Definition- Primary Care Provider	Adds the definition of "primary care provider" under health maintenance organization statute.
171	Primary Care Providers	Changes the word "primary care physician" to "primary care provider" in statute requiring health maintenance organizations to cover mental health services for non-biologically based mental disorders in children if the child was diagnosed by a primary care provider.
172	Primary Care Providers	Changes the word "primary care physician" to "primary care provider" in statute permitting health maintenance organizations to require a member to alert their primary care provider if they received emergency care.
173.31	Primary Care Attribution	Requires health maintenance organizations to attribute every member to a primary care provider.
173.32	Transparency- Patient-level Data and Prices (Effective 10/1/2013 - §291)	Requires health maintenance organizations to A) disclose patient-level data to providers in their network for the purpose of carrying out treatment, coordinating care, and managing the care of their patients; and B) disclose the contracted prices of health services to providers who are under alternative payment contracts, for the purpose of referrals.
174	Wellness Program- Insurance Rate Discounts	Directs the Division of Insurance to determine the criteria for individual and small groups to quality for a wellness program rate discount.
175	Medical Loss Ratio (Effective 4/1/2014 - §302)	Reduces the medical loss ratio an insurer must meet to have their base rates approved by the Division of Insurance from 90 percent to 89 percent.
176	Medical Loss Ratio (Effective 4/1/2015 - §303)	Reduces the medical loss ratio an insurer must meet to have their base rates approved by the Division of Insurance from 89 percent to 88 percent.
177	Smart Tiering Plan (Effective 4/1/2013 - §308)	Permits insurance carriers to offer a "smart tiering plan" in which health services (rather than providers) are tiered and member cost sharing is based on the tier placement of services. Increases the rate discount for any select or tiered

Section #	Topic	Summary
		network from at least 12 percent to at least 14 percent.
178	Technical Amendment	Relative to DHCFP and CHIA.
179	Small Business Group Purchasing Cooperatives	Requires premium rates offered to a certified group purchasing cooperative to be based on those rates that apply to plans outside of the cooperative. However, rates for cooperatives may differ based on: 1) a difference in benefits; 2) a difference in the projected experience of members; or 3) any other rate adjustment factor resulting in a discount of up to 10%.
180.16	Primary Care Attribution –Small Group	Requires carriers offering small group plans to attribute every member to a primary care provider.
180.17	Transparency- Patient-level Data and Prices (Effective 10/1/2013 - §292)	Requires carriers offering small group plans to A) disclose patient-level data to providers in their network for the purpose of carrying out treatment, coordinating care, and managing the care of their patients; and B) disclose the contracted prices of health services to providers who are under alternative payment contracts, for the purpose of referrals.
181	Technical Amendment	Relative to DHCFP and CHIA.
182	Technical Amendment	Relative to DHCFP and CHIA.
183	Definition - Behavioral Health Manager	Amends the definition of "behavioral health manager" under the health insurance consumer protection statute to include substance use disorder and mental health services.
184	Definition - Downside Risk	Defines "downside risk" under the health insurance consumer protection statute as risk taken on by a provider organization as part of an alternate payment contract where the provider organization is responsible to either the full or partial costs that exceed a contract's budget.
185	Definition – Emergency Medical Condition	Amends the definition of "emergency medical condition" under the health insurance consumer protection statute to include a behavioral or substance use disorder condition.
186	Definition – Health Care Services	Amends the definition of "health care services" under the health insurance consumer protection statute to include a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.
187	Definition- Primary Care Provider	Adds the definition of "primary care provider" under health insurance consumer protection statute.
188	Definition – Risk-Bearing Provider	Defines "risk-bearing provider organization" under the health insurance

Section #	Topic	Summary
	Organization	consumer protection statute as a provider organization that manages the treatment of a group of patients and bears the downside risk according to the terms of an alternate payment contract.
189	Technical Amendment	Relative to DHCFP and CHIA.
190	Technical Amendment	Relative to DHCFP and CHIA.
191	Coding	Directs the Commissioner of Insurance to notify carriers if they are out of compliance with uniform coding standards and guidelines for health care claims. Imposes a $5,000/day fine for failing to come into compliance.
192	Evidence of Coverage	Adds to insurers' "evidence of coverage" document 1) the toll-free number and website a consumer may contact to find out the allowed amount or charge for a proposed service and the estimated amount the consumer will be expected to pay out-of-pocket; and 2) an explanation that a carrier will cover services and the patient will not be required to pay more out-of-pocket than for an in-network service whenever: A) a medically necessary service is not available in-network; or B) services are delivered by out-of-network providers in an in-network location.
193	Technical Amendment	Relative to DHCFP and CHIA.
194	Technical Amendment	Relative to DHCFP and CHIA.
195	Primary Care Providers	Changes the word "primary care physician" to "primary care provider" in statute giving insureds' the right to request referral assistance from their health carrier if the insured or the insured's primary care provider has difficulty identifying medically necessary services within the carrier's network.
196	Technical Amendment	Relative to DHCFP and CHIA.
197	Prohibited Contract Provisions	Prohibits carriers from entering into a contract with a health care provider if the contract: A) limits the carrier or provider from disclosing the allowed amount and fees of services to an insured or an insured's provider; or B) limits the ability of either the carrier or health care provider from disclosing out-of-pocket costs to an insured.
198	Risk Certificates	Prohibits carriers from entering into or continuing alternate payment arrangements involving downside risk with provider organizations that have not received a risk certificate.
199	Utilization Review	Requires utilization review criteria be made accessible and up-to-date on a

Section #	Topic	Summary
	(Effective 10/1/2015 - §304)	carrier or utilization review organization's website.
200	Medical Necessity – Pre-Service Review (Effective 10/1/2013 - §305)	Requires carriers and utilization review organizations to make a determination of medical necessity of a proposed service within 7 working days upon the request of an insured or the insured's provider.
201	Continued Coverage	Changes the word "primary care physician" to "primary care provider" in statute governing the right of a patient to continue receiving services from their primary care provider for 30 days after said provider is removed from their insurer's network or if said provider is not in-network under their employer's new health plan.
202	Medical Necessity - Disclosure	Requires carriers and utilization review organizations to apply medical necessity criteria consistently and make such criteria accessible and up-to-date on their website.
203	Primary Care Provider	Changes the word "primary care physician" to "primary care provider" in statute pertaining to a behavioral health manager requiring a member to alert their primary care provider if they received emergency care.
204	Technical Amendment	Relative to DHCFP and CHIA.
205	Reporting	Allows the Division of Insurance to waive financial reporting requirements for classes of carriers for which the commissioner deems such reporting requirements to be inapplicable.
206.23	Transparency - Charges	Directs carriers to establish a toll-free number and website that enables consumers to obtain from the carrier, within 2 working days, the allowed amount or charge for a proposed service and the estimated amount the consumer will be expected to pay out-of-pocket. Consumers are protected from paying more than the disclosed amount.
206.24	Internal Appeals (Effective 10/1/2013 - §293)	Requires risk-bearing provider organizations to create an internal appeals process for aggrieved patients. Such appeals process must be completed within 14 days or 3 days for an emergency medical situation. Patient's have the right to a 3rd party advocate in the appeals process. Requires the Office of Patient Protection to establish an external review process.
207	Transparency - Charges	Shortens the period in which a carrier must report to a consumer the allowed amount or charge for a proposed service and the estimated amount the consumer will be expected to pay out-of-pocket from 2 days (as established in Section

Section #	Topic	Summary
		206.23) to real time.
207A.25	Administrative Simplification- Prior Authorization Forms (Effective 1/1/2014 - §294)	Directs the Division of Insurance to develop and implement uniform prior authorization forms. Requires payers to use such forms when requesting prior authorization.
207A.26	Administrative Simplification - Health Plan Eligibility	Directs the Division of Insurance to establish standardized procedures for the determination of a patient's health benefit plan eligibility at or prior to the time of a service.
207A.27	Administrative Simplification – Summary of Payments Form	Directs the Division of Insurance to develop a common summary of payments forms to be used by all payers.
208	Definition – Dependent	Adds the definition of "dependent" to the Commonwealth Health Insurance Connector statute.
209	Definition - Division	Strikes the definition of "division" from the Commonwealth Health Insurance Connector statute.
210	Definitions – Fiscal Year and Free Care	Adds the definitions of "fiscal year" and "free care" to the Commonwealth Health Insurance Connector statute.
211	Definitions – Medically Necessary Services and Non-Providing Employer	Adds the definitions of "medically necessary services" and "non-providing employer" to the Commonwealth Health Insurance Connector statute.
212	Definition – Payments from Non-Providing Employers	Adds the definition of "payments from non-proving employers" to the Commonwealth Health Insurance Connector statute.
213	Definition – State-Funded Employee	Adds the definition of "state-funded employee" to the Commonwealth Health Insurance Connector statute.
214	Definition – Uninsured Patient	Adds the definition of "uninsured patient" to the Commonwealth Health Insurance Connector statute.
215.17	Employer Health Insurance Responsibility Disclosure	Transfers the responsibility of preparing and collecting the employer and employee health insurance responsibility disclosure forms from DHCFP to the Connector Authority.
215.18	Free Rider Surcharge	Transfers the responsibility of assessing the free rider surcharge from DHCFP to the Connector Authority.
216.176S.1	Physician Assistants –Definitions	Definitions section.
216.176S.2	Physician Assistants –Participating	Requires carriers to recognize physician assistants as participating providers.

Section #	Topic	Summary
	Providers	
216.176S.3	Physician Assistants –Primary Care Providers	Establishes physician assistants as primary care providers.
216.176S.4	Physician Assistants – Primary Care Providers	Allows insureds to select a physician assistant as their primary care provider.
216.176S.5	Physician Assistants – List of Participating Providers	Requires carriers to list physician assistants in any publicly accessible list of participating providers for the carrier.
216.176S.6	Physician Assistants - Noncompliance	Requires DOI or the GIC to investigate complaints against the carrier for noncompliance with this chapter.
216.176T.1	Risk-Bearing Provider Organizations - Definitions	Definitions section. Defines "risk-bearing provider organization" as a provider organization that manages the treatment of a group of patients and bears the downside risk according to terms of an alternative payment contract.
216.176T.2	Risk-Bearing Provider Organizations - Insurance	Establishes that risk-bearing provider organizations are not subject to General Laws pertaining to insurers unless said organization assumes a significant portion of downside risk.
216.176T.3	Risk-Bearing Provider Organizations – Risk Certificates	Requires registered provider organizations that enter into or renew an alternative payment contract in which the provider organization accepts downside risk to file an application for a risk certificate with the Division of Insurance.
216.176T.4	Risk-Bearing Provider Organizations - Audits	Permits DOI to audit risk-bearing provider organizations regarding its alternative payment arrangements with downside risk once every 3 years.
216.176T.5	Risk-Bearing Provider Organizations – Risk Certificates	Directs DOI to provide notice to a risk-bearing provider organization if said organization's alternative payment contracts with downside risk are likely to threaten its financial solvency. Allows DOI to suspend, cancel, or not issue a risk certificate under certain circumstances.
216.176T.6	Risk-Bearing Provider Organizations – Patient Protection	Prohibits health care providers from attempting to collect from a patient any money owed to the provider by a risk-bearing provider organization.
216.176T.7	Risk-Bearing Provider Organizations – Information Sharing	Makes all information provided by risk-bearing provider organizations to DOI under this chapter available to HPC and CHIA.
216.176T.8	Risk-Bearing Provider Organizations	Establishes that this chapter does not exempt any person from applicable provisions under General Laws pertaining to the Department of Public Health, the Registration of Professions or Risk-Bearing Provider Organizations.

Section #	Topic	Summary
216.176T.9	Risk-Bearing Provider Organizations -Regulations	Directs DOI to promulgate regulations to carry out the provisions of this chapter.
218	Technical Amendment	Relative to DCHFP becoming CHIA.
219	Technical Amendment	Relative to the Office of Medicaid and EOHHS.
220	Medical Malpractice- Interest Rate	Reduces the interest rate for medical malpractice from +4% to +2%
221.60L	Medical Malpractice- Cooling off Period	Creates a new 182-day cooling off period for medical malpractice claims. Patients must file a notice of intent to sue and are barred from filing until the passage of 182 days. Requires exchange of information between plaintiff and defendant to encourage early settlement.
222	Medical Malpractice-Non-profit Damages Cap	Raises the non-profit damages cap from $20k to $100k.
223	Medical Malpractice-Apology	Allows a health care provider or facility to admit to a mistake or error. The admission cannot be used in court as an admission of liability. However if a provider lies under oath about the error or mistake then it can be used as an admission of liability.
224	Medical Malpractice-Allowable Expenses	States that claimant hospital expenses will be covered if claimant demonstrates an out of pocket loss and the claim is certified by the facility that those expenses are not covered by Medicaid already. Amount awarded shall not exceed amount established for such services.
225	Technical Amendment	Relative to the Executive Director of the Health Insurance Connector.
226	Technical Amendment	Relative to the Executive Director of the Health Insurance Connector.
227	Technical Amendment	Relative to Enrollees in Commonwealth Care.
228	Technical Amendment	Relative to the setting of rates paid by Government.
229	Technical Amendment	Relative to the setting of rates paid by Government.
230	Technical Amendment	Relative to the setting of rates paid by Government.
231	Technical Amendment	Relative to physicians' use of electronic health records.
232	Technical Amendment	Relative to the approval of rates by the Commissioner of Insurance.
233	Technical Amendment	Relative to the Statewide Quality Advisory Commission.
234	Small group rating factors	Provides for a rate shock bumper relative to an individual or small groups premium.
235	Technical Amendment	Relative to the approval of rates by the Commissioner of DOI.

Section #	Topic	Summary
236	Technical Amendment	Relative to the setting of rates paid by Government.
237	Powers of EOHHS	EOHHS still administers medical assistance and children's health programs.
238	Wellness Tax Credit	DOR shall review the wellness tax credit in consultation with DPH to determine if it met its public policy objectives.
239	Wellness Tax Credit	Wellness Tax Credit amount shall not exceed $15M total for all participants.
240	HIT Council and E-Health Institute	HIT Council and the E Health Institute shall conduct an evaluation of the expenditures of the HIE Fund.
241	Hospital Surcharge	The Health Policy Commission shall establish a surcharge for those hospitals that exceed $1B in total net assets and less than 50% of their payer mix is Government payer. The surcharge will equal $60M and each hospitals percentage will be determined by dividing each hospitals operating surplus by the total operating surplus of those paying the surcharge. Waivers up to 66% of the surcharge may be granted if a hospital receives more than 25% of payment from Medicare or their net assets do not exceed $1.25B. The HPC shall establish a surcharge for payors of $165M. Each payor's percentage will be determined by dividing the surcharge payor's payments for acute hospital services divided by the total payments for acute hospital services by all surcharge payors. Can make the payment in a single amount by June 30, 2013 or in 4 yearly installments. 60% or a total of $135M to the Distressed Hospital Fund, 26 and 2/3% or $60M to the Wellness and Prevention Trust Fund, and 13 and 1/3% or $30M to the E-Health Institute Fund. 5% of each distribution shall be deposited into the Health Care Payment Reform Fund for the administration of the Health Policy Commission. Failure to pay by a provider or payor shall result in a civil penalty of $5k a day. Providers and Payors may not increase rates or premiums to pay for the surcharge.
242	Third Party Administrator Disclosure	Every 3rd party administrator must disclose to their self-insured clients the contracted price of in network providers.
243	ACO-Medical Home EMR's	ACO's, Medical Homes, and licensed risk-bearing organizations must have interoperable EMR's by December 31, 2016.
244	Health Care Workforce Center Joint Appointments	The HCWC shall investigate the feasibility of joint appointments for clinicians with universities and agencies.

Section #	Topic	Summary
245	Nursing home waiver	EOHHS shall seek a waiver to the federal requirement that admission to a nursing facility be preceded by a 3 day hospital stay.
246	Medicare Termination of Benefits	The office of Medicaid shall not terminate a patient's coverage if that patient has submitted requested documentation by the date stated to determine eligibility.
247	Durable Medical Equipment	The Secretary of A+F and the Secretary of EOHHS shall look into the feasibility of contracting for the recycling of durable medical equipment.
248	Termination of Benefits	The Office of Medicaid in consultation with DUA and EOHHS shall develop and implement a system where the Office of Medicaid can access information regarding status of or termination of unemployment benefits for the purposes of determining eligibility for health insurance programs administered by EOHHS.
249	DOI Telemedicine Review	DOI in consultation with the board of medicine shall issue a report on the potential of out of state physicians to practice telemedicine in the Commonwealth.
250	Veterans Health Benefits	Directs EOHHS to look at methods to improve access to Department of Veterans Affairs benefits for veterans and if feasible move them off of MassHealth and onto those programs.
251	Auditor Review	Directs the Auditor to do an independent review of the impact of the bill and on the payment and delivery system.
252	Supplemental Insurance	Nothing in the act shall be construed to bar for a consumer from obtaining any additional insurance coverage.
253	Critical Access Hospital Payment	Directs Medicaid, Commonwealth Care, and the Group Insurance Commission to reimburse critical access hospitals at 101% of allowable costs.
254	Mental Health Parity	Directs the Division of Insurance to promulgate regulations requiring all carriers to comply with state and federal Mental Health Parity Laws.
255	DON Effective date	States that no projects that have applications filed with DPH on or before December 31, 2013 will be subject to the new DON requirements.
256	State Health Plan	The Health Planning Council shall submit its report to the Legislature by January 1, 2014.
257	DON exemption	Health Care Providers that receive written notice from DPH by December 31, 2013 shall be exempt from filing a DON for said project.

Section #	Topic	Summary
258	Board of Medicine Continuing Education	The Board of Medicine may as part of its continuing education requirements offer education and training regarding the early disclosure of adverse events.
259	DPH –Wellness Guide	Directs the Division of Insurance (DOI) to create a model wellness guide to explain the benefits of wellness programs. The guide will illustrate the potential savings for consumers, employers and payers.
260	Board of Nursing Continuing Education	The Board of Nursing may as part of its continuing education requirements offer education and training regarding the early disclosure of adverse events.
261	Medicaid-Alternative Payment Methodologies	Requires Medicaid to pay for health care using alternative payment methodologies for 25%, 50% and 80% of its enrollees by the middle of 2013, 2014 and 2015, respectively.
262	Medicaid Rate Increases	MassHealth, in FY14, will provide a rate increase of 2% for providers that have made a significant transition to alternative payment methodologies. Aggregate amount of increase may not exceed $20 million.
263	Study on Health Savings Accounts	HPC will conduct a study on increasing the use and adoption of Flexible Spending Accounts, Health Reimbursement Arrangements, Health Savings Accounts and other similar tax-favored health plans. The study to be completed by April 1, 2013.
264	Pilot Program on Health Savings Accounts Study	The Department of Revenue will conduct a study into the feasibility of a pilot program on Health Savings Accounts, Flexible Savings Accounts and similar type of programs. The study will review 1) the barriers to full implementation of these types of accounts; 2) affect on consumer choice; and 3) incentives to increase the use of these accounts. The study to be completed by April 1, 2013.
265	Federal Mental Health Parity	Requires MassHealth to promulgate regulations that requires any Medicaid Health Plan or Managed Care Organization to comply with state and Federal Mental Health Parity Laws. MassHealth will submit an annual report starting on July 1, 2014 on the level of compliance.
266	Social Security Numbers on Public Benefit Forms	Requires MassHealth, within 6 months, to take actions to ensure that Social Security numbers are submitted with all medical benefit requests forms.

Section #	Topic	Summary
		Requires EOHHS, within 6 months, to require identity, age, residence, and eligibility of all applicants to be verified before payments are made by the Health Safety Net.
267	Children's Health Insurance Program – Express Lane	EOHHS will, to the maximum extent possible, allow children and families to automatically renew eligibility into MassHealth through the adoption of Express-Lane Eligibility. EOHHS will be required to enter into negotiations with CMS to allow the use of Express-Lane Eligibility. Forms should be available by January 1, 2014. EOHHS will conduct a study on the feasibility and cost of continuous enrollment for children under the age of 19 to ensure the same health plan as a child moves between MassHealth and Commonwealth Care. The report to be completed by June 30, 2014.
268	Model ACO Prioritization	Public Payers such as GIC, MassHealth and the Connector will prioritize their contracting preferences with Model ACOs.
269	Transfer Funding	CHIA, during FY13 – FY17, will transfer funds to HPC for the operation of functions being transferred from CHIA to HPC.
270	Special Commission on Public Payer Reimbursement Rates	Creates a 13 member commission to review the payments of public payers as it compares to quality, safety, effective, timely and patient centered care. The review will look into other potential sources of dollars for public program. It will review the impact of these rates on providers and premiums for private insurance. The report to be completed by April 1, 2013.
271	Medicaid Payments – Chronic Disease Rehabilitation	In FY 2014, Chronic Disease Rehabilitation Hospitals for Children will receive inpatients reimbursement equal to 1.5 times the rate for FY12. In FY15 and FY16, the rates cannot be lower than the previous fiscal year.
272	Betsy Lehman Center Task Force	Creates a Task Force with up to 11 persons to review the effect of Defensive Medicine and Medical Overutilization in the Commonwealth.
273	Commission on Pharmaceutical Cost Containment	Creates a 16 member commission to review 1) the ability of the state to enter into bulk purchasing agreements; 2) aggregate purchasing methodologies to lower pharmaceutical costs for government and private purchasers; 3) ability for the state to act as a single payer for pharmaceutical products; and 4) feasibility of creating a program to provide all citizens with access to state negotiated pharmaceuticals.

Section #	Topic	Summary
274	Special Task Force on the Accuracy of Medical Diagnoses	Creates a 9 person Task Force to review 1) the extent to which diagnoses are accurate and reliable; 2) underlying systemic issues that result in inaccurate diagnoses; 3) estimated costs associated with inaccurate diagnoses; 4) negative impact on patients receiving inaccurate diagnoses; and 5) recommended actions.
275	Behavioral Health Task Force	Creates a 19 member Task Force to review 1) the most effective and appropriate approach to include behavioral health services in services provided by provider organizations and PCMHs; 2) potential modifications to the reimbursement of behavioral health services; 3) the extent to which and how payment for behavioral health services should be included in alternative payment methodologies; 4) how to best educate providers to identify behavioral health issues; 5) how to best educate providers on detrimental effects to physical health in patients with serious behavioral health issues; and 6) unique privacy issues related to integrating behavioral health information into interoperable health records. The report to be completed by July 1, 2013.
276	Commission on Prevention and Wellness	Creates a 20 member commission to review the effectiveness of the programs offered under the Prevention and Wellness Trust Fund. The report to be completed by June 30, 2015.
277	Special Commission on Graduate Medical Education (GME)	Creates a 13 member commission to examine the value of graduate medical education in the commonwealth and to recommend a sustainable model for funding GME.
278	Government Implementation of Alternative Payment Methodologies	By July 1, 2014, public payers, to the extent possible, must implement alternative payment methodologies.
279	Special Commission on Provider Price Variation	Creates an 18 member commission to review acceptable and unacceptable factors contributing to price variation in physician, hospital, diagnostic testing and ancillary services. The report will be due by January 1, 2014.
280	Government Payers – Alternative Payments and Waivers	Requires that Government Payers such as the Connector, GIC and MassHealth, to the maximum extent possible, implement Alternative Payment Methodologies. EOHHS must look for any necessary Federal Waivers to Medicare to allow for the use of Alternative Payment Methodologies.
281	Agency Transfer Authority	Provides for the orderly transfer of employees, proceedings, rules, regulations, property and legal obligations of the DHCFP to CHIA.
281A	Effective Date	Oct. 1, 2013 for Subsections (c) and (d) Section 24 of Chapter 176O – Internal

Section #	Topic	Summary
		Appeals for Risk Bearing Provider Organizations.
281B	Effective Date	Jul. 1, 2014 for Section 26 of Chapter 176O– Administrative Simplification: Patient Eligibility.
282	No Section 282	--
283	Effective Date	Jan. 1, 2013 for Section 13 of Chapter 6D – Market Impact Reviews.
284	Effective Date	Jul. 1, 2016 for Section 6 of Chapter 6D – Funding Mechanism for HPC.
285	Effective Date	Jan. 1, 2014 for Section 228 of Chapter 111 – Provider Transparency.
286	Effective Date	Jan. 1, 2017 for Section 7 of Chapter 118I – Requiring Interoperability for All Provider.
287	Effective Date	Jan. 1, 2017 for Section 6 of Chapter 118I – Providing Patient Access to Medical Records.
288	Effective Date	Oct. 1, 2013 for Section 108M of Chapter 175 – Transparency of Patient Level Data for Providers.
289	Effective Date	Oct. 1, 2013 for Section 37 of Chapter 176A – Transparency of Patient Level Data for Providers.
290	Effective Date	Oct. 1, 2013 for Section 24 of Chapter 176B – Transparency of Patient Level Data for Providers.
291	Effective Date	Oct. 1, 2013 for Section 32 of Chapter 176G – Transparency of Patient Level Data for Providers.
292	Effective Date	Oct. 1, 2013 for Section 17 of Chapter 176J – Transparency of Patient Level Data for Providers.
293	Effective Date	Oct. 1, 2013 for Section 24 of Chapter 176O – Internal Appeals Process Procedures for Risk Bearing Provider Organizations.
294	Effective Date	Jan. 1, 2014 for Section 25 of Chapter 176O – Administrative Simplification: Uniform Forms for Prior Authorization.
295	Effective Date	Oct. 1, 2013 for Section 36 of the Bill – Consumer Transparency for GIC Products.
296	Effective Date	Oct. 1, 2014 for Section 37 of the Bill – Amendment to Consumer Transparency for GIC Products.
297	Effective Date	Jan. 1, 2013 for Sections 41 and 56 of the Bill – Workplace Wellness Tax Credit.

Section #	Topic	Summary
298	Effective Date	Dec. 31, 2017 for Sections 41A and 56A of the Bill – Workplace Wellness Tax Credit Repeal.
299	Effective Date	Jan. 1, 2015 for Section 108 of the Bill – Physician Proficiency in HIT.
300	No Section 300	--
301	Effective Date	Jul. 1, 2013 for Section 141 and 142 of the Bill – Fair Share Contribution: FTE Level & Employers with other Insurance.
302	Effective Date	Apr. 1, 2014 for Section 175 of the Bill – Medical Loss Ratio.
303	Effective Date	Apr. 1, 2015 for Section 176 of the Bill – Medical Loss Ratio.
304	Effective Date	Oct. 1, 2015 for Section 199 of the Bill – Utilization Review.
305	Effective Date	Oct. 1, 2013 for Section 200 of the Bill – Medical Necessity: Pre-Service Review.
306	Section 271 Repealed (Effective 6/30/2016 - §307)	Repeals Section 271 of the Bill – Chronic Disease Rehabilitation Hospitals for Children.
307	Effective Date	June 30, 2016 for Section 306 – Chronic Disease Rehabilitation Hospitals for Children.
308	Effective Date	Apr. 1, 2013 for Section 177 – Tiering Plan Rate Discounts.