December 17, 2008

[House Emergency Preamble] *Whereas,* The deferred operation of this act would tend to defeat its purpose which is forthwith to expand access to health care for Massachusetts residents, therefore it is hereby declared to be an emergency law, necessary for the immediate preservation of the public health and convenience.

SECTION 1. [House 1, Senate 4, Conference Comp] Chapter 6A of the General Laws is hereby amended by inserting after section 16~~I~~G the following ~~new~~ section:-

~~Section 16H. Massachusetts health care quality and cost council~~

~~Section 1. There shall be established a health care quality and cost council within, but not subject to control of, the executive office of health and human services. The council shall establish health care quality improvement and cost containment goals for the commonwealth. The goals shall be designed to promote high quality, safe, effective, timely, efficient, equitable, and patient-centered health care. The council shall receive staff assistance from the executive office of health and human services, and may, subject to appropriation, employ such additional staff or consultants as may be deemed necessary by the Council. The council shall consist of the secretary of health and human services, *the Auditor of the Commonwealth or his designee, the Inspector General or his designee, the Attorney General or his designee,* the commissioner of insurance, the executive director of the group insurance commission, and seven members appointed by the governor, one of whom shall be a representative of a health care quality improvement organization (QIO) recognized by the federal Centers for Medicare and Medicaid services, one of whom shall be a representative of the Institute for Healthcare Improvement, Inc, recommended by the organization's board of directors, one of whom~~

~~shall be a representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, one of whom shall be a representative of the Massachusetts Association of Health Underwriters, one of whom shall be a representative of the Massachusetts Medicaid Policy Institute, one of whom shall be an expert in health care policy from a foundation or academic institution, and one of whom shall represent a non-governmental purchaser of health insurance. The representatives of non-governmental organizations shall serve staggered three-year terms. The council shall be chaired by the secretary of health and human services.~~

Section 16~~J~~A. ~~Definitions~~.

As used in this section~~.~~ and in sections 16K and 16L, the following terms shall have the following meanings unless the context clearly requires otherwise:

~~"Council", the health care quality and cost council established in section 2.~~

"Clinician", a~~ny~~ health care professional~~s~~ licensed pursuant to chapter 112 ~~of the General Laws~~.

"Council", the health care quality and cost council established in section 16K.

"Facility", a hospital, clinic or nursing home licensed pursuant to chapter 111 or a home health agency.

"Health care provider", a clinician, a facility or a physician group practice.

"Insurer", a carrier authorized to transact accident and health insurance pursuant to chapter 175, a nonprofit hospital service corporation licensed pursuant to chapter 176A, a nonprofit medical service corporation licensed pursuant to chapter 176B, a dental

service corporation organized pursuant to chapter 176E, an optometric service corporation organized pursuant to chapter 176F and a health maintenance organization licensed pursuant to chapter 176G.

"Physician group practice", 2 or more physicians who deliver patient care, make joint use of equipment and personnel, and divide income by a prearranged formula.

Section 16K. There shall be a health care quality and cost council within, but not subject to control of, the executive office of health and human services. The council shall establish health care quality improvement and cost containment goals. The goals shall be designed to promote high-quality, safe, effective, timely, efficient, equitable and patient-centered health care. The council shall receive staff assistance from the executive office of health and human services and may, subject to appropriation, employ such additional staff or consultants as it may deem necessary. The council shall consist of the secretary of health and human services, *the auditor of the commonwealth or his designee, the inspector general or his designee, the attorney general or his designee,* the commissioner of insurance, the executive director of the group insurance commission, and 7 members to be appointed by the governor, 1 of whom shall be a representative of a health care quality improvement organization recognized by the federal Centers for Medicare and Medicaid services, 1 of whom shall be a representative of the Institute for Healthcare Improvement, Inc. recommended by the organization's board of directors, 1 of whom shall be a representative of the Massachusetts Chapter of the National Association of Insurance and Financial Advisors, 1 of whom shall be a representative of the Massachusetts Association of Health Underwriters, 1 of whom shall be a representative of the Massachusetts Medicaid Policy Institute, 1 of whom shall be an expert in health

care policy from a foundation or academic institution and 1 of whom shall represent a non-governmental purchaser of health insurance. The representatives of nongovernmental organizations shall serve staggered 3-year terms. The council shall be chaired by the secretary of health and human services.

Section 16L. (a)~~Section 2. The duties of the council shall include the following:~~

~~(1)~~ ~~(a)~~ The council shall develop and coordinate the implementation of health care quality improvement goals ~~for the commonwealth~~ that are intended to lower or contain the growth in health care costs while improving the quality of care, including reductions in racial and ethnic health disparities. For each such goal, the cCouncil shall identify the steps needed to achieve the goal; estimate the cost of implementation; project the anticipated short-term or long-term financial savings achievable to the health care industry and the cCommonwealth, and estimate the expected improvements in the health status of health care consumers in the commonwealth~~Massachusetts~~.

(b)

~~(b)~~ The council may, subject to ~~the provisions of ch~~chapter 30B ~~of the general laws~~, contract with an independent health care organization to provide the council with technical assistance related to its duties including, but not limited to, the development of health care quality goals, cost containment goals, performance measurement benchmarks, the design and implementation of health quality interventions, the construction of a consumer health information web-site and~~as well as~~ the preparation of reports, including any reports as required by this section. ~~.~~ The independent health care organizations shall

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have a history of demonstrating the skill and expertise necessary to: ~~:~~ ~~(~~i) collect, analyze and aggregate data related to costs and quality across the health care continuum; (ii) identify, through data analysis quality improvement areas; (iii) work with Medicare, Mass Health, other payers' data and clinical performance measures; (iv) collaborate in the design and implementation of quality improvement measures; establish and maintain security measures necessary to maintain confidentiality and preserve the integrity of the data; (vi) design and implement health care quality improvement interventions with health care service providers; and (vii) identify and, when necessary, develop appropriate measures of cost and quality for inclusion in the web-site.

To the extent possible, the independent organization shall collaborate with other organizations that develop, collect and publicly report health care cost and quality measures.

(c) Any independent organization under contract with the board shall develop and update on an annual basis a reporting plan specifying the cost and quality measures to be included on the internet site. The reporting plan shall be consistent with the requirements of subsections ~~(~~1~~)~~(a) and (b). The organization shall give consideration to those measures that are already available in the public domain and to whether it is cost effective for the board to license commercially available comparative data and consumer decision support tools. If the organization determines that making available through the internet site only those measures already available in the public domain would not fully comply with subsection ~~1~~(b) or would not provide consumers with sufficient information to make informed health care choices, the organization shall develop appropriate measures

for inclusion on the internet site and shall specify in the reporting plan the sources from which it proposes to obtain the data necessary to construct those measures and any specifications for reporting of that data by insurers and health care providers.

—As part of the reporting plan, the organization shall determine for each service that comparative information is to be included on the internet site whether it is more practical and useful to: (1) list that service separately or as part of a group of related services; and (2) combine the cost information for each facility and its affiliated clinicians and physician practices or to list facility and professional costs separately.

—The independent organization shall submit the reporting plan, and any periodic revisions, to the council. The council shall, after due consideration and public hearing, adopt or reject the reporting plan or any revisions. If the council rejects the reporting plan or any revisions, the board shall state its reasons therefore. The reporting plan and any revisions adopted by the board shall be promulgated by the board.

(d). Insurers and health care providers shall submit data to the council or to the independent organization on behalf of the council, as required by regulations promulgated pursuant to subsection 8. Any insurer or health care provider failing, without just cause, to submit required data to the council on a timely basis may be required, after notice and hearing, to pay a penalty of $1,000 for each week's delay; provided, however, that t The maximum penalty under this section shall be $50,000.

(e) The Council may promulgate additional rules and regulations relative to the type of information that may be required and the format in which it should be provided for the implementation the quality improvement and cost containment goals.

(f2) The council may adopt by-laws for itself and for its advisory committee for the efficient operation of both organizations, and may recommend that public or private health care organizations be responsible for overseeing implementation of a goal, and may assist these organizations in developing implementation plans.

(g3) The council shall develop performance measurement benchmarks for its goals and publish such benchmarks annually, after consultation with lead agencies and organizations and the council's advisory committee. Such benchmarks shall be developed in a way that advances a common national framework for quality measurement and reporting, including, but not limited to measures that are approved by the National Quality Forum and adopted by the Hospitals Quality Alliance and other national groups concerned with quality. Performance benchmarks shallould be clinically important and include both process and outcome data, shalland be standardized, timely, and allow and encourage physicians, hospitals and other health care professionals to improve their quality of care. Any data reported by the council should be accurate and evidence-based, and not imply distinctions where comparisons are not statistically significant. Members of the advisory committee shallould have reasonable opportunity to review and comment on all reports before public release.

(4) (he) The council shall establish and maintain a consumer health information website. The website shall contain information comparing the cost and quality of health care services and may also contain general information related to health care as the council determines to be appropriate. The website shall be designed to assist consumers in making informed decisions regarding their medical care and informed choices between

health care providers. Information shall be presented in a format that is understandable to the average consumer. The council shall take appropriate action to publicize the availability of its website ~~site~~ and make available written documentation available upon request and as necessary.

~~(b)Not later than July 1, 2006, the internet site shall be operational and, at a minimum, include links to other internet sites that display comparative cost and quality information.~~

~~(c) Not later than January 1, 2007, the internet site shall, at a minimum, include comparative cost information by facility and, as applicable, by clinician or physician group practice for obstetrical services, physician office visits, high volume elective surgical procedures, high volume diagnostic tests and high volume therapeutic procedures. Cost information shall include, at a minimum, the average payment for each service or category or service received by each facility, clinician or physician practice on behalf of insured patients. Cost information shall be aggregated for all insurers and the board shall not publicly release the payment rates of any individual insurer which shall not be deemed to be public records as defined in chapter 66 of the general laws.~~

(~~b~~c) The internet site shall provide updated information on a regular basis, at least annually, and additional comparative cost and quality information shall be posted as determined by the board. To the extent possible, the internet site shall include: (i) comparative quality information by facility, clinician or physician group practice for each service or category of service for which comparative cost information is provided, (ii)

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general information related to each service or category of service for which comparative information is provided; and (iii) comparative quality information by facility, clinician or physician practice that is not service-specific, including information related to patient safety and satisfaction.

(j5) The council shall conduct annual public hearings to obtain input from health care industry stakeholders, health care consumers, and the general public regarding the goals and the performance measurement benchmarks. The council shall invite the stakeholders involved in implementing or achieving each goal to assist with the implementation and evaluation of progress for each goal.

(k6) The council shall review and file a report, not less than annually, with the clerks of the hHouse and sSenate on its progress in achieving the goals of improving quality and containing or reducing health care costs ~~in the Commonwealth.~~ Reports of the council shall be made available electronically through an internet site.

(l7) The council shall establish an advisory committee to allow the broadest possible involvement of health care industry and other stakeholders in the establishment of its goals and the review of its progress. The advisory committee shall include ~~l~~one member representing the Massachusetts Medical Society, ~~l~~one member representing the Massachusetts Hospital Association, ~~l~~one member representing the Massachusetts Association of Health Plans, ~~l~~one member representing Blue Cross Blue Shield of Massachusetts, ~~l~~one member representing the Massachusetts AFL-CIO, ~~l~~one member representing the Massachusetts League of Community Health Centers, ~~l~~one member representing Health Care For All, ~~l~~one member representing the Massachusetts Public

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Health Association, ~~1~~one member representing the Massachusetts Association of Behavioral Health Systems, ~~1~~one member representing the Massachusetts Extended Care Federation, ~~1~~one member representing the Massachusetts Council of Human Service Providers, ~~1~~one member representing the Home and Health Care Association of Massachusetts, ~~1~~one member representing Associated Industries of Massachusetts, ~~1~~one member of the Massachusetts Business Roundtable, ~~1~~one member of the Massachusetts Taxpayers Foundation, ~~1~~one member of the Massachusetts Chapter of the National Federation of Independent Business, 1 member of the Massachusetts Biotechnology Council, ~~1~~one member representing the Blue Cross/Blue Shield Foundation, ~~1~~one member representing the Massachusetts chapter of the American Association of Retired Persons, ~~1~~one member representing the Massachusetts Coalition of Taft Hartley Trust Funds, and additional members to be appointed by the Governor, which shall include, but not be limited to, a representative of the mental health field, a representative of pediatric health care, a representative of primary care, a representative of medical education, a representative of racial or ethnic minority groups concerned with health care, a representative of hospice care, a representative of the nursing profession, and a representative of the pharmaceutical field.

(m8) ~~–~~The council may recommend ~~any~~ legislation or regulatory changes, including recommendations concerning the methodology for reimbursement payments necessary to carry out its goals, and the council ~~may~~shall ~~have the authority to~~ promulgate regulations under this section.

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(n9) Subject to appropriation, the council may disburse funds in the form of grants or loans to assist members of the health care industry in implementing the goals of the council.

(10o) All meetings of the council shall conform to ~~the provisions of~~ chapter 30A ~~of the general laws~~, except that the council, through its bylaws, may provide for executive sessions of the council. No act of the council shall be taken in an executive session.

(p11) The members of the council shall not receive a salary or per diem allowance for serving as members of the council but shall be reimbursed for actual and necessary expenses incurred in the performance of their duties. The~~Said~~ expenses may include reimbursement for~~of~~ travel and living expenses while engaged in council business.

(q12) The council may, subject to ~~the provisions of c~~chapter 30B ~~of the general laws,~~ and subject to appropriation, procure equipment, office space, goods and services, including the development and maintenance of the web-site ~~provided in subsection 4~~.

SECTION . The website to be established pursuant to section 16L of chapter 6A of the General Laws shall be operational not later than July 1, 2006 and shall included, at a minimum, links to other internet sites that display comparative cost and quality information. Not later than January 1, 2007, the internet site shall, at a minimum, include comparative cost information by facility and, as applicable, by clinician or physician group practice for obstetrical services, physician office visits, high-volume elective

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surgical procedures, high-volume diagnostic tests and high-volume therapeutic procedures. Cost information shall include, at a minimum, the average payment for each service or category or service received by each facility, clinician or physician practice on behalf of insured patients. Cost information shall be aggregated for all insurers and the board shall not publicly release the payment rates of any individual insurer which shall not be deemed to be public records as defined in chapter 66 of the General Laws.

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SECTION 2. [Senate SECTION 3A] Section 35M of chapter 10 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out, in lines 10 and 11, the words:— "and administration; but, any unexpended balance at the end of the fiscal year shall revert to the General Fund." and inserting in place thereof the following words:— ", administration and the statutory and regulatory responsibilities of the board including patient protection, physician education and health care quality improvement."

SECTION 3. [House 2; Senate 3A Conference Comp] Chapter 17 of the General Laws is hereby amended by striking out section 3, as so appearing, and inserting in place thereof the following sections:--

Comment [DES1]: Besides third-reading changes, edits to this section also include the following recommendations that I discussed with House Counsel and Senate conference staff: (1) stagger initial terms; and (2) provide for direct appointments by organizations, rather than by Governor/AG.

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~~SECTION~~ Section 3. (a) There shall be a public health council to advise the commissioner of public health and to perform other duties as required by law. The council shall consist of the commissioner of public health as chairperson and 16 members appointed ~~by the governor~~ for terms of 6 years in accordance with this section. ~~The governor shall appoint members within 60 days of the effective date of this act.~~ The

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

(b) Four of the appointed members shall be the chancellor of the University of Massachusetts Medical School or his designee; the dean of the University of Massachusetts Amherst School of Public Health and Health Sciences~~,~~ or his designee; the dean of the Harvard University School of Public Health or his designee; and the dean of the Boston University School of Public Health or his designee.

(c) Six of the appointed members shall be providers of health services: 1 shall be the chief executive officer of an acute care hospital nominated by the Massachusetts Hospital Association; 1 shall be the chief executive officer of a skilled nursing facility ~~nominated~~ appointed by the Massachusetts Extended Care Federation; 2 shall be registered nurses, to be ~~nominated~~ appointed by the board of registration of nurses and shall be the highest vote-getters on a mail ballot sent to the address of record of all registered nurses licensed by the board of registration of nurses, ~~provided that~~ 1 of whom shall be a nurse executive; and 2 shall be physicians appointed by the Massachusetts Medical Society, ~~one~~ 1 of whom shall be a primary care physician.

(d) Six of the appointed members shall be non-providers: 1 shall be ~~nominated~~ appointed by the secretary of elder affairs; 1 shall be ~~nominated~~ appointed by the secretary of veterans' services; 1 shall be ~~nominated~~ appointed by Health Care For All, Inc.; 1 shall be ~~nominated~~ appointed by the Coalition for the Prevention of Medical Errors, Inc.; 1 shall be ~~nominated~~ appointed by the Massachusetts Public Health Association; and 1 shall be ~~nominated~~ appointed by the Massachusetts Community Health Worker Network.

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

(~~c~~f) Upon the expiration of the term of office of an appointive member, his or her successor shall be appointed in the same manner as the original appointment, for a term of 6 years and until the qualification of ~~his or~~ her successor. The council shall meet at least once a month, and at such other times as it shall determine by its rules, or when requested by the commissioner or any 4 members. The appointive members shall receive $100 aper day ~~while in conference~~that the council meets, and their necessary traveling expenses while in the performance of their official duties.

SECTION [at end of bill]. The members of the public health council established by section 3 of chapter 17 of the General Laws shall be appointed not later than 60 days after the effective date of this act. The terms of office of all the appointed~~incumbent~~ members of the public health council, ~~established pursuant to section 3 of chapter 17 of the general laws,~~ holding office on the effective date of this act, shall ~~be deemed expired~~expire whenever 8 of the appointed members of the council have been appointed

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under this act, notwithstanding any expiration date stated at the time of their appointment or reappointment. Of the initial 16 members of the council appointed under this act, half in each category, as designated by the commissioner of public health, shall serve initial terms of 3 years, and the remaining half shall serve initial terms of 6 years.

~~SECTION 3A. Notwithstanding any general or special law to the contrary, the members of the public health council established in section 3 of chapter 17 of the General Laws shall be appointed not later than 60 days from the effective date of this act. If, at any time, the council shall consist of fewer than 16 members, the Attorney General shall appoint such members after 60 days, so that the council consists of 16 members as provided in said chapter 17.~~SECTION 4. [House 3; Senate 3D, Conf Staff compromise] Chapter 26 of the General Laws is hereby amended by inserting after section 7 the following 2 sections:—

Section 7A. There shall be in the division of insurance a health care access bureau overseen by a deputy commissioner for health care access, whose duties shall include, subject to the direction of the commissioner of insurance, administration of the division's statutory and regulatory authority for oversight of the small group and individual health insurance market, oversight of affordable health plans, including coverage for young adults, as well as the dissemination of appropriate information to consumers ~~relative to~~about health insurance coverage and access to affordable products. The commissioner shall appoint ~~all~~ at least the following employees of the health care access bureau~~ The bureau shall consist of at least the following employees who shall devote their full time to the duties of their office and shall be exempt from chapters 30 and 31 and shall serve at~~

~~the pleasure of the commissioner~~: a deputy commissioner for health access, a health care finance expert, an actuary, and a research analyst. They shall devote their full time to the duties of their office, shall be exempt from chapters 30 and 31, and shall serve at the pleasure of the commissioner. The commissioner may appoint such other employees as the bureau may require.

Section 7B. For the purposes of implementing ~~the provisions of~~ chapter 111M, the health care access bureau ~~in the division of insurance~~ shall maintain a database of members of health benefit plans. Carriers licensed under chapters 175, 176A, 176B, and 176G and the office of Medicaid shall report on the first day of each month to the bureau the names, and any other identifying information as determined by the division of insurance, of each resident of the commonwealth for whom creditable coverage, as defined in chapter 111M, was provided during the previous month. The division shall enter into an inter-agency agreement with the department of revenue for purposes of implementing chapter 111M and, in consultation with the department of revenue, shall ~~promulgate~~ adopt regulations defining the content of such reports, which shall be limited to the minimum amount of personal information necessary for the purposes of chapter 111M. These reports shall not contain any information pertaining to previous or current health conditions or treatments. The division of insurance ~~is authorized to~~ may transfer the content of the database to the department of revenue for the purposes of implementing chapter 111M.

SECTION 5. [House 4] ~~Said~~ Section 8H of said chapter 26, as appearing in the 2004 Official Edition, is hereby further amended by inserting after the second paragraph the following paragraph:—

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

SECTION 6. [House 5; Senate 5.5]

Chapter 29 of the General Laws is hereby amended by inserting after section 2NNN the following section:-

Section 2*OOO*. There is hereby established and set up on the books of the commonwealth a separate fund to be known as the commonwealth care fund, ~~hereinafter referred to as~~ in this section called the fund. There shall be credited to the fund (a) all health care contributions collected pursuant to **[the employer assessment]**, (b) any federal reimbursement received for benefits and payments provided pursuant to chapters **118G** and 118H, and (d) any other appropriations or monies made available by law for the purposes of the demonstration program approved the Secretary of the United States Department of Health and Human Services pursuant to section 1115 of the Social Security Act, as extended or renewed from time to time. Amounts credited to the fund shall be expended, subject to appropriation, for ~~(a)~~ programs designed to increase health

coverage, including a program of subsidized health insurance provided to low-income residents of the commonwealth pursuant to chapter 118H~~, and (b) a program of health assistance provided to adults pursuant to clause (j) of subsection (2) of section 9A of chapter 118E,~~ **[add language allowing use for rate increases??]**~~, provided however that m~~ Moniesey from the fund may be transferred to the health safety net trust fund, established by section 57 of chapter 118E, **as necessary to provide payments to acute hospitals and community health centers for reimbursable health services.** Not later than January ~~first~~1, the comptroller shall report an update of revenues for the current fiscal year and prepare estimates of revenues to be credited to the fund in the subsequent fiscal year. ~~Said~~ The comptroller shall file this report ~~shall be filed~~ with the secretary of administration and finance, the ~~commissioner of medical assistance~~office of Medicaid, the joint committee on health care financing, and the house and senate committees on ways and means. ~~In the event that~~If revenues credited to the fund are less than the amounts estimated to be credited to the fund, the comptroller shall duly notify ~~said~~ the secretary, ~~commissioner~~ office and committees that ~~said~~ this revenue deficiency shall require proportionate reductions in expenditures from the revenues available to support programs appropriated from the fund.

[effective date: July 1, 2006]

SECTION 7. [Senate 5A] Section 1 of chapter 32 of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by inserting after the word "Authority", in line 211, the first time it appears,~~191~~ the following words:— , ~~C~~commonwealth ~~Care H~~health ~~I~~insurance ~~Exchange Corporation~~connector.

SECTION 8. [Senate 6A, Conference Comp] Section 2 of chapter 32B of the General Laws, as so appearing, is hereby amended by inserting after the word "commonwealth", in line 65, the following words: —, and ~~any federally recognized Indian Tribe as referenced in 25 U.S.C. section 1771 et seq~~the Wampanoag Tribal Council of Gay Head, Inc.

SECTION 9. [House 7; Senate 7, House Language] Section 1 of chapter 62 of the General Laws~~, as appearing in the 2004 Official Edition,~~ is hereby amended by striking out paragraph (c), as amended by section 3 of chapter 163 of the acts of 2005, and inserting in place thereof the following paragraph:—

(c) "Code", the Internal Revenue Code of the United States, as amended on January 1, 2005 and in effect for the taxable year; ~~provided, however, that~~but Code shall mean the Code as amended and in effect for the taxable year for sections 62(a)(1), 72, 223, 274(m), 274(n), 401 through 420, inclusive, 457, 529, 530, 3401 and 3405 but excluding sections 402A and 408(q).

SECTION 10. [House 8; New Senate bill, Conf Staff Compromise]

The General Laws are hereby amended by inserting after chapter 111L, as appearing in section 1 of chapter 27 of the acts of 2005, the following chapter:-

CHAPTER 111M

INDIVIDUAL HEALTH COVERAGE

December 17, 2008

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

"Creditable coverage", coverage of an individual under any of the following health plans or as a named beneficiary receiving coverage on another's plan with no lapse of coverage for more than 63 days: (a) a group health plan; (b) a health plan, including, but not limited to, a health plan issued, renewed or delivered within or without the commonwealth to an individual who is enrolled in a qualifying student health insurance program pursuant to section 18 of chapter 15A or a qualifying student health program of another state; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) 10 U.S.C. 55; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under 5 U.S.C. 89; (i) a public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701(c)(1)(I), as amended by Public Law 104-191; (j) a health benefit plan under the Peace Corps Act, 22 U.S.C. 2504(e); (k) coverage for young adults pursuant to section 10 of chapter 176J; (l) a nongroup health plan or ~~(k.m)~~ any other qualifying coverage required by the Health Insurance Portability and Accountability Act of 1996, as ~~it is~~ amended, or by regulations promulgated under that act.

Comment [RLW2]: (l) A nongroup health plan, or *<depending on merger/nonmerger>*

"Resident", a person who has

(1) obtained an exemption pursuant to clause Seventeenth, Seventeenth C, Seventeenth C ½, Seventeenth D, Eighteenth, Twenty-second, Twenty-second A, Twenty-second B, Twenty-second C, Twenty-second D, Twenty-second E, Thirty- seventh, Thirty-seventh A, Forty-first, Forty-first A, Forty-first B, Forty-first C, Forty-second or Forty-third of section 5 of chapter 59;

(2) obtained an exemption pursuant to section 5C of said chapter 59;

(3) filed a Massachusetts resident income tax return pursuant to chapter 62;

(4) obtained a rental deduction pursuant to subparagraph (9) of paragraph (a) of Part B of section 3 of chapter 62;

(5) declared in a home mortgage settlement document that the mortgaged property located in the commonwealth would be occupied as his principal residence;

(6) obtained homeowner's liability insurance coverage on property that was declared to be occupied as a principal residence;

(7) filed a certificate of residency and identified his place of residence in a city or town in the commonwealth in order to comply with a residency ordinance as a prerequisite for employment with a governmental entity;

(8) paid on his own behalf or on behalf of a child or dependent of whom the person has custody, resident in-state tuition rates to attend a state-sponsored college, community college or university;

(9) applied for and received public assistance from the commonwealth for himself or his child or dependent of whom he has custody;

(10) has a child or dependent, of whom he has custody, who is enrolled in a public school in a city or town in the commonwealth, unless the cost of such education is paid for by him, such child or dependent, or by another education jurisdiction;

(11) is registered to vote in the commonwealth;

(12) obtained any benefit, exemption, deduction, entitlement, license, permit or privilege by claiming principal residence in the commonwealth; or

(13) is a resident under any other written criteria under which the commissioner of revenue may determine residency in the commonwealth.

Section 2. (a) As of January 1, 2007, the following individuals age 18 and over shall obtain and maintain creditable coverage: (1) residents of the commonwealth; or (2) individuals who become residents of the commonwealth within 63 days, in the aggregate, and for whom creditable coverage is deemed affordable under the schedule set by the board of the connector. Residents who within 63 days have terminated any prior creditable coverage, shall obtain and maintain creditable coverage within 63 days of such termination.

(b) Every person who files an individual income tax return as a resident of the commonwealth, either separately or jointly with a spouse, shall indicate on the return, in a manner prescribed by the commissioner of revenue, whether such person had creditable coverage in force for each of the 12~~twelve~~ months of the taxable year for which the return is filed as required under paragraph (a) whether covered as an individual or as a named beneficiary of a policy covering multiple individuals. If the person fails to indicate or indicates that he did not have such coverage in force, then a penalty shall be assessed on

the return. If the person indicates that he had such coverage in force but the commissioner determines, based on the information available to him, that such requirement of paragraph (a) was not met, then the commissioner shall assess the penalty.

(c) If in any taxable year, in whole or in part, a taxpayer does not comply with the requirement of paragraph (a), the commissioner shall retain any amount overpaid by the taxpayer for purposes of making payments described in paragraph (d); provided, however, that the amount retained shall not exceed 50 per cent of the minimum insurance premium for creditable coverage for which the individual would have qualified during the previous year. The penalty shall~~will~~ be assessed for each of the months the individual did not meet the requirement of paragraph (a); provided, that any lapse in coverage of 63 days or less shall not be counted in calculating the penalty; and, provided further, that nothing in this paragraph shall be considered to authorize the commissioner to retain any amount for such purposes that otherwise would be paid to a claimant agency or agencies as debts described in subsections (i) to (vii), inclusive, of section 13 of chapter 62D. If the amount retained is insufficient to meet the penalty assessed, the commissioner shall notify the taxpayer of the balance due on the penalty and related interest. **The penalty shall be treatable as taxes due under chapter 62A.C**

Comment [ESF3]: Chapter 62A was repealed by chapter 590 of the acts of 1972.

(d) The commissioner shall deposit all penalties collected into the Ccommonwealth cCare fFund, established inby section *2000* of chapter 29.

Section 3. An individual subject to Section 2, who disputes the determination of compliance as enforced by the department of revenue, may seek a review of this determination through an appeal established by the board of the commonwealth

health insurance connector, pursuant to chapter 176Q; provided, however, that no additional penalties shall be enforced against an individual seeking review until the review is complete and any subsequent appeals are exhausted.

Section 4. The commissioner of revenue, in consultation with the board of the commonwealth health insurance connector established by ~~C~~chapter 176Q, shall promulgate such rules and regulations, as necessary, to carry out the purposes of this chapter,

SECTION 11. [House 9; Senate 12, Conf Comp] Subsection (2) of section 9A of chapter 118E of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out clause (c) and inserting in place thereof the following clause:—

(c) children and adolescents, from birth to 18 years, inclusive, whose financial eligibility as determined by the division exceeds 133 per cent but is not more than 300 per cent of the federal poverty level, including such children and adolescents made eligible for medical benefits under this chapter by Title XXI of the Social Security Act.

Effective: 7/1/06

SECTION 12. [House 11; Senate 13E, Conf Comp] ~~Clause (h) of subsection (2) of~~ Said section 9A of said chapter 118E ~~of the General Laws~~, as so appearing, is hereby further amended by inserting after the word "eligibility", in line 112, the following words:— ; provided, however, that the division shall not establish disability criteria for applicants or

recipients which are more restrictive than ~~the~~those criteria authorized by Title XVI of the Social Security Act, 42 U.S.C. 1381 et seq.

SECTION 13. [House 12; Senate 12A] Said~~Subsection (2) of~~ section 9A of said chapter 118E ~~of the General Laws~~, as so appearing, is hereby further amended ~~in line 115~~ by striking out ,in line 115, the figure "133" and inserting in place thereof the following figure:— "200".

Effective 7/1/06

SECTION 14. [House 14, in part] Said section 9A of said chapter 118E, as so appearing, is hereby further amended by adding the following subsection:—

(15) The office of Medicaid shall report monthly to the health care access bureau in the division of insurance, as established in~~by~~ chapter 26, section 7A, ~~monthly~~ a listing of all individuals for whom creditable coverage is provided as of the first day of the month.

SECTION 15. [House 15; Senate 13] Section 9C of said chapter 118E is hereby amended by striking out the definition "Eligible employee" ~~appearing in lines 16 to 21~~ and inserting in place thereof the following definition:--

"Eligible employee", an employee: (i) that is employed by~~an employee of~~ an eligible employer; (ii) who resides in the commonwealth; (iii) who has not attained age

Comment [SAN4]: As redrafted, this section would maintain the current IP program and would expand the income eligibility threshold for employees from 200 to 300 FPL (for self-employed the level would remain 200). It would not change the size of the employer subsidy, and would maintain the current business size criterion at 50 employees. New crowd out language is also added—the goal is to use IP to cover employees whose employers won't agree to the provisions of the subsidy program, but to avoid cost-shifting by employers.

65; (iv) whose employer or family member's employer has not in the last 6 months provided insurance coverage for which the individual is eligible; and (v) who meets the financial and other eligibility standards set forth in regulations promulgated by the division, ~~if~~~~provided, however, that~~ the gross family income standard does~~shall~~ not exceed 300 per cent of the federal poverty level.

SECTION 16. [House 15; Senate 13] Section 9C of said chapter 118E, as so appearing, is hereby amended by inserting after the words "eligible employees", in line 56, the following words:- "and, provided further, that the amount of said subsidy shall not be greater than that of the subsidy the employee would have received if enrolled in the subsidized insurance program created in chapter 118H.

Comment [SAN5]: More new IP language. MAY NEED MORE LANGUAGE??

SECTION 17. [House 16, Senate 13A, Conf Comp] ~~The fourth paragraph of s~~Section 12 of said chapter 118E, as so appearing, is hereby amended by inserting after the word "Secretary.", in line 33, ~~adding~~ the following sentence:— Rules and regulations which restrict eligibility or covered services require a public hearing in accordance with section 2 of chapter 30A.

SECTION 18. [House 17; Senate 41] Said chapter 118E is hereby further amended by inserting after section 13A the following section:—

Section 13B. Hospital rate increases shall be made contingent upon hospital adherence to quality standards and achievement of performance benchmarks, including

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the reduction of racial and ethnic disparities in the provision of health care. Such benchmarks shall be developed or adopted by the executive office of health and human services so as to advance a common national framework for quality measurement and reporting, drawing on measures that are approved by the National Quality Forum and adopted by the Hospitals Quality Alliance and other national groups concerned with quality, in addition to the Boston Public Health Commission Disparities Project Hospital Working Group Report Guidelines. The office of Medicaid may also use recommended benchmarks from the health care quality and cost council established in~~by~~ section 16H of chapter 6A. [Implementation date October 1, 2007]

SECTION 19. Notwithstanding any general or special law to the contrary, for hospital rate year commencing October 1, 2007 only, hospitals may appeal to the division of health care finance and policy to receive ~~medicaid~~Medicaid hospital rate increases without meeting the quality standards and achieving performance benchmarks established by the executive office of health and human services pursuant to section 13B of chapter 118E. [Implementation date October 1, 2007] [repeal October 1, 2008]

SECTION 20. [House 18; Senate 13B, Conf Comp] Section 16C of said chapter 118E, as so appearing, is hereby amended by striking out, in lines 4 and 20, the figure "200", each time it appears, and inserting in place thereof, in each instance, the following figure:— 300.

Effective: 7/1/06

December 17, 2008

SECTION 21. [House 19; Senate 13B 3/5]

Section 16D of said chapter 118E, as so appearing, is hereby amended by adding the following subsection:—

(7) Notwithstanding subsection (3), a person who is not a citizen of the United States but who is either a qualified alien within the meaning of section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 or is otherwise permanently residing in the United States under color of law shall be eligible to receive benefits under MassHealth Essential if such individual meets the categorical and financial eligibility requirements pursuant to MassHealth ~~; provided, further, that~~if such individual is either age 65 or older, or between age 19 and~~to~~ 64, inclusive, and disabled. ~~; provided, further, that any s~~Such individual shall not be subject to sponsor income deeming or related restrictions.

Effective: 7/1/06

SECTION 22. [House 20]

The seventh paragraph of section 23 of said chapter 118E, as so appearing ~~in the 2004 Official Edition~~, is hereby amended by striking out clause (2) and inserting in place thereof the following clause:--(2) persons for whom hospitals and community health centers claim payments from the health safety net fund under chapter 118E.

[effective date=Oct 1, 2007]

SECTION 23. [House 21; Senate 13B 4/5, Conf. staff compromise]

Said chapter 118E is hereby further amended by adding the following 2 sections:—

Section 53. The division shall include within its covered services for adults all federally optional services that were included in its state plan in effect on January 1, 2002.

Section 54. The executive office of health and human services shall implement, in cooperation with the department of public health, a wellness program for MassHealth enrollees to encourage activities that lead to desired health outcomes, including smoking cessation, diabetes screening for early detection, teen pregnancy prevention, cancer screening for early detection, and stroke education for enrolled individuals. To the extent enrollees comply with the goals of the wellness program, the executive office shall reduce MassHealth premiums and/or copayments proportionally. The executive office shall report annually on the number of enrollees who meet at least 1~~one~~ wellness goal, the premiums collected from the enrollees, and the reduction of premiums due to enrollees meeting wellness goals to the joint committee on health care financing and the house and senate committees on ways and means.

Effective: 7/1/06

SECTION 24. [House 22]

~~Said chapter 118E is hereby amended by adding the following six new sections:~~

Section 55. As used in this section and sections 56~~5~~ to~~through~~ 60, inclusive, the following words shall have the following meanings, unless the context clearly requires otherwise. ~~have the following meanings:—~~

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Comment [SAN6]: A number of new definitions have been added to this section to support language in following sections and to reflect changes in conference bill, such as reinstatement of surcharge payor language.

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

"Allowable reimbursement", payment to acute hospitals and community health centers for health services provided to uninsured patients of the commonwealth **in accordance with** ~~the provisions of~~ **section 60** ~~of this chapter, provided that such payments shall be made in accordance with~~ **and any further** regulations promulgated by the office.

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

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

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

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

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

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

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

"Essential community provider", a community health center, a community health center-based managed care organization, or an acute hospital that exhibits a payer mix where a minimum of ~~sixty-three~~63 per cent of the acute hospital's gross patient service revenue is attributable to Title XVIII and Title XIX of the federal Social Security Act or other governmental payors, including reimbursements from the Health Safety Net Fund.

Financial requirements", a hospital's requirement for revenue which shall include, but not be limited to, reasonable operating, capital and working capital

Comment [SAN7]: New def relevant to creation of a successor to the distressed provider fund.

costs, and the reasonable costs associated with changes in medical practice and technology.

"Fund", the health safety net **trust** fund, established by section 57.

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

"Gross pPatient sService rRevenue", the total dollar amount of a hospital's charges for services rendered in a fiscal year.

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

"Office", the health safety net office, ~~as~~ established in~~by~~ section 56.

"Payments subject to surcharge", all amounts paid, directly or indirectly, by surcharge payors to acute hospitals for health services and ambulatory surgical centers for ambulatory surgical center services, as defined in section 1 of chapter 118G ~~on or after the effective date of this section~~; provided, however, that "payments subject to surcharge" shall not include: (i) payments, settlements, and judgments arising out of third party liability claims for bodily injury which are paid

under the terms of property or casualty insurance policies; (ii) payments made on behalf of Medicaid recipients, Medicare beneficiaries, or persons enrolled in policies issued pursuant to chapter 176K or similar policies issued on a group basis; and provided further, that "payments subject to surcharge" may exclude amounts established in regulations promulgated by the division for which the costs and efficiency of billing a surcharge payor or enforcing collection of the surcharge from a surcharge payor would not be cost effective.

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

"Reimbursable health services", health services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or part, pursuant to applicable regulations of the office**; provided that such services shall not be eligible for reimbursement by any other public or private third-party payer; and** provided **further** that non-emergency and **non**-urgent services shall be provided at a community health center unless no community or hospital licensed health center **providing both adult and pediatric primary care** is located within ~~five~~5 miles of a hospital campus, as determined by the office **or if the patient's medical condition is so severe or complex that appropriate care cannot be adequately provided in a community health center setting,** as determined by the office.

Comment [SAN8]: MHA proposal

Comment [SAN9]: Also MHA proposal

"Resident", a person living in the commonwealth, as defined by the office by regulation; provided, however, that such regulation shall not define as a resident a person who moved into the commonwealth for the sole purpose of securing health insurance

under this chapter. Confinement of a person in a nursing home, hospital or other medical institution shall not in and of itself, suffice to qualify such person as a resident.

"Surcharge payor", an individual or entity that pays for or arranges for the purchase of health care services provided by acute hospitals and ambulatory surgical center services provided by ambulatory surgical centers, as defined in section 1 of chapter 118G; provided, however, that the term "surcharge payor" shall not include Title XVIII and Title XIX programs and their beneficiaries or recipients, other governmental programs of public assistance and their beneficiaries or recipients, and the workers' compensation program established ~~inpursuant to~~ **chapter 152.**

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

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

Section 56. (a) There is hereby established a health safety net office within the office of Medicaid. The director of the office ~~of Medicaid~~ shall, in consultation with the secretary of health and human services, appoint the director of the health safety net office. The director shall have such educational qualifications and administrative and other experience as the commissioner and secretary determine to be necessary for the

performance of the duties of director, including, but not limited to, experience in the field of health care financial administration.

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

(1) to administer the Health Safety Net Trust Fund established in~~by~~ section 57 ~~of this chapter~~ and to require payments to the fund consistent with acute hospitals' liability to the fund, as determined pursuant to section 58, and any further regulations promulgated by the office;

(2) to set, after consultation with the division of health care finance and policy established by section 2 of chapter 118G, reimbursement rates for payments from the fund to acute hospitals and community health centers for **reimbursable** health services provided to uninsured **and underinsured** patients and to disburse monies from the fund consistent with such rates; ~~provided that said rates are set established by section 2 of chapter 118G;~~ provided, ~~further~~ that the office shall implement a fee-for-service reimbursement system for acute hospitals;

(3) to promulgate regulations further defining: (A~~a~~) eligibility criteria for reimbursable health services; (B~~b~~) the scope of health services that are eligible for reimbursement by the Health Safety Net Trust Fund; (C~~c~~) standards for medical hardship; and (~~d~~D) standards for reasonable efforts to collect payments for the costs of emergency care. The office shall implement procedures for verification of eligibility using the eligibility system of the office of Medicaid and other appropriate sources to determine the eligibility of uninsured **and underinsured** patients for reimburse~~d~~**able** health services and shall establish other procedures to ensure that payments from the fund are made for health services for which there is no other public or private third party

payer, including disallowal of payments to acute hospitals and community health centers for free care provided to individuals if reimbursement is available from other public or private sources; and

(4)(A) to develop programs and guidelines to encourage maximum enrollment of uninsured individuals who receive health services reimbursed by the fund into health care plans and programs of health insurance offered by public and private sources, and (~~b~~B) to promote the delivery of care in the most appropriate setting, provided that thesaid programs and guidelines are developed in consultation with the commonwealth health insurance connector, established by chapter 176Q. Such programs shall not deny payments from the fund because services should have been provided in a more appropriate setting if the hospital was required to provided such services pursuant to 42 USC 1395 (dd);

Comment [SAN10]: Adjust to reflect any language changes re: connector.

(5) to conduct a utilization review program designed to monitor the appropriateness of services for which payments were made by the fund and to promote the delivery of care in the most appropriate setting; and to administer demonstration programs that reduce health safety net **trust** fund liability to acute hospitals, including a demonstration program to enable disease management for patients with chronic diseases, substance abuse and psychiatric disorders through enrollment of patients in community health centers and community mental health centers, and through coordination between these centers and acute hospitals, **provided, that the office shall report the results of such reviews annually to the joint committee on health care financing and the hHouse and sSenate committees on ways and means;**

(6) to administer the Health Safety Net Trust Fund~~separate account established in section 57~~ and to make expenditures from that account without further appropriation for the purpose of improving and enhancing the ability of essential community providers to serve populations in need of community-based care, including, but not limited to, clinical support, care coordination services, and pharmacy management services; provided, however, that i~~In awarding the grants, the office shall consider, but not be limited to, criteria such as the financial requirements of the provider, the percentage of patients with mental or substance abuse disorders served by a provider, the numbers of patients served by a provider who are chronically ill, elderly, or disabled, and the cultural and linguistic challenges presented by the populations served by the provider;

(7) to enter into agreements or transactions with any federal, state or municipal agency or other public institution or with a~~ny~~ private individual, partnership, firm, corporation, association or other entity, and to make contracts and execute all instruments necessary or convenient for the carrying on of its business;

(8) to secure payment, without imposing undue hardship upon any individual, for unpaid bills owed to acute hospitals by individuals ~~that~~ **for health services that** are ineligible for reimbursement from the H~~h~~ealth S~~s~~afety N~~n~~et T~~t~~rust f~~F~~und which have been accounted for as bad debt by the hospital and which are voluntarily referred by a hospital to the department for collection; provided, however that such unpaid charges shall be considered debts owed to the commonwealth and ~~that~~ all payments received shall be credited to the fund~~health safety net trust fund~~; and provided, further, that all actions

Comment [SAN11]: This would replace the current Distressed Provider Fund which receives MCO supp $$.

to secure such payments shall be conducted in compliance with a protocol previously submitted by the office to the joint committee on health care financing; and

(9) to make, amend, and repeal rules and regulations to effectuate the efficient use of monies from the Health Safety Net Trust Fund. ~~Such~~; provided, however, that the regulations shall be adopted only after notice and hearing and only upon consultation with the board of the commonwealth health insurance ~~of the~~ connector, the secretary of ~~the executive office of~~ health and human services, the director of the office of Medicaid, and representatives of the Massachusetts Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts Safety Net Hospitals, and the Massachusetts League of Community Health Centers.

Section 57. (a) There is hereby established a Health Safety Net Trust Fund, hereinafter referred to as the fund, which shall be administered by the health safety net office ~~established pursuant to section 56~~. Expenditures from the fund~~said Trust Fund~~ shall not be subject to appropriation unless otherwise required by law. The purpose of the fund shall be~~is~~ to maintain a health care safety net by reimbursing hospitals and community health centers for a portion of the cost of services provided to low-income, uninsured or underinsured residents of the commonwealth and by providing support for essential community providers. The office shall administer the fund using such methods, policies, procedures, standards and criteria that it deems necessary for the proper and efficient operation of the fund and programs funded thereby in a manner designed to distribute the fund resources as equitably as possible.

Comment [SAN12]: to allow a portion of safety net funds to be used for distressed provider activities (assuming transfer of DP fund to within new pool).

(b) The fund shall consist of all amounts paid by acute hospitals **and surcharge payors pursuant to sections 58 and 59;** all appropriations for the purpose of payments to acute hospitals or community health centers for health services provided to uninsured **and underinsured** residents; amounts paid by employers pursuant to.. **[ADD LANGUAGE RE: FREE RIDER SURCHARGE BEING DEPOSITED HERE]**; any transfers from the Ceommonwealth Ceare fFund established inby section 2*000* of chapter 29; and all property and securities acquired by and through the use of monies belonging to thesaid fund and all interest thereon. Amounts placed in the fund shall, except for amounts transferred to the Ceommonwealth Ceare Ffund, be expended by the office for the purpose of payments to hospitals and community health centers for reimbursable health services provided to uninsured **and underinsured** residents of the commonwealth, consistent with the requirements of this section and section 60 and the regulations promulgated by the office; , provided, that $6,000,000 shall be expended annually from the fund for demonstration projects that use case management and other methods to reduce the liability of the fund to acute hospitals, and **provided further, that any annual balance remaining in the fund after such payments have been made shall be transferred to the Commonwealth Care Fund established in** said **section 2*000* of** said Cchapter **29. [ADD LANGUAGE RE: MAXIMIZING FEDERAL REIMBURSEMENT AND STIPULATING THAT FEDERAL REIMBURSEMENT GENERATED FROM EXPENDITURES FROM THIS FUND SHOULD BE DEPOSITED IN THE COMMONWEALTH CARE FUND??].** All interest earned on the amounts in the fund shall be deposited or retained in the fund. The director shall from time to time requisition from thesaid fund such amounts as hethe

Comment [SAN13]: Moved this language up from below in earlier draft.

~~director~~ deems necessary to meet the current obligations of the office for the purposes of the fund and estimated obligations for a reasonable future period. **[ADD LANGUAGE ALLOWING USE OF SOME AMOUNT OF FUNDS TO BE USED FOR ADMINISTRATION OF OFFICE??]**

(c) Within ~~the~~said fund, the office shall establish a separate account ~~to~~ provide~~for the purpose of providing~~ grants to essential community providers. Th~~e~~is separate account shall consist of amounts transferred from the Health Safety Net Trust Fund, amounts transferred from the Commonwealth Care ~~fund~~, and any funds that may be appropriated for deposit into th~~e~~is account. The office ~~of~~ shall administer th~~e~~is account and disburse funds from th~~e~~is account for ~~the purpose of~~ payments to essential community providers in accordance with ~~provisions of~~ clause (6) of ~~subsection~~paragraph (b) of section 56 and any further regulations promulgated by the office.

Section 58. (a) An acute hospital's liability to the fund shall equal the product of (1) the ratio of its private sector charges to all acute hospitals' private sector charges; and (2) the acute hospital liability **to the fund** as determined by law. Before October 1 of each year, the office, in consultation with the division of health care finance and policy, shall establish each acute hospital's liability to the fund using the best data available, as determined by the division, and shall update each acute hospital's liability to the fund as updated information becomes available. The office shall specify by regulation an appropriate mechanism for interim determination and payment of an acute hospital's liability to the fund.

Comment [SAN14]: This section establishes a separate account within the fund that would be used to provide grants to essential community providers—a.k.a. distressed providers. This would replace the current distressed provider fund. This account would be funded either via a transfer from regular free care funds or with new federal SN dollars, since a portion of these can be used for infrastructure, etc. Note this language also eliminates the current separate account set up to pay for IP (which I believe is dormant).

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

(c) The office shall establish by regulation an appropriate mechanism for enforcing an acute hospital's liability to the fund in the event that an acute hospital does not make a scheduled payment to the fund. ~~Such~~ These enforcement mechanisms may include (1) notification to the office of Medicaid requiring an offset of payments on the Title XIX claims of any such acute hospital or any health care provider under common ownership with the acute care hospital or any successor in interest to the acute hospital, and (2) the withholding by the office of Medicaid of the amount of payment owed to the fund, including any interest and late fees, and the transfer of the withheld funds into the ~~f~~Fund. If the office of Medicaid offsets claims payments as ordered by the office, it shall not be ~~deemed~~ considered to be in breach of contract or any other obligation for the payment of noncontracted services, and providers ~~to which~~ **whose** payment is offset under order of the division shall serve all Title XIX recipients in accordance with the contract then in effect with the office of Medicaid, or, in the case of a noncontracting or disproportionate share hospital, in accordance with its obligation for providing services to Title XIX recipients ~~pursuant to~~under this chapter. In no event shall the office direct the office of Medicaid to offset claims unless an acute hospital has maintained an outstanding obligation to the health safety net fund for a period longer than 45 days and has received proper notice that the~~said~~ division intends to initiate enforcement actions ~~in accordance with~~under the regulations of the office.

Section 59. (a) Acute hospitals and ambulatory surgical centers shall assess a surcharge on all payments subject to surcharge as defined in section 1 of chapter 118G. The surcharge shall be distinct from any other amount paid by a surcharge payor for the services of an acute hospital or ambulatory surgical center. The surcharge amount shall equal the product of (i) the surcharge percentage and (ii) amounts paid for ~~said~~ these services by a surcharge payor. The office shall calculate the surcharge percentage by dividing $160,000,000 by the projected annual aggregate payments subject to the surcharge, ~~provided that~~but beginning on October 1, 2008 and in each following year, ~~thereafter~~ this amount shall be adjusted to reflect increases in the consumer price index calculated by the United States Bureau of Labor Statistics for all urban consumers nationally during the most recent 12 month period for which data is~~are~~ available. The office shall determine the surcharge percentage before the effective date of this section and may redetermine the surcharge percentage before the following April 1 if the office projects that the initial surcharge established the previous October will produce less than $150,000,000 or more than $170,000,000. Before each succeeding October 1, the office shall redetermine the surcharge percentage incorporating any adjustments from earlier~~prior~~ years. In each determination or redetermination of the surcharge percentage, the office shall use the best data available as determined by the division and may consider the effect on projected surcharge payments of any modified or waived enforcement under subsection (e) of section 18A of chapter 118G. The office shall incorporate all adjustments, including, but not limited to,

Comment [SAN15]: This is same language as current 118G:18A, surcharge amount is changed to codify current practice of assessing $160 million and inflation-adj language is added.

updates or corrections or final settlement amounts, by prospective adjustment rather than by retrospective payments or assessments.

Section 60. (a) Reimbursements from the ~~F~~fund to hospitals and community health centers for health services provided to uninsured individuals shall be made in the following manner, and shall be subject to further rules and regulations promulgated by the office.

(1) Reimbursements made to acute hospitals shall be based on actual claims for health services provided to uninsured and underinsured patients that are submitted to the office, and shall be made only after determination that the claim is eligible for reimbursement ~~in accordance with~~under this chapter and any additional regulations promulgated by the office,~~, provided that R~~reimbursements for health services provided to residents of other states and foreign countries shall be prohibited, and ~~provided further that~~ the office shall make payments to acute hospitals using fee-for-service rates calculated as provided in subparagraph (2)~~ below~~.

(2) The office shall, in consultation with the office of Medicaid, develop and implement procedures to verify the eligibility of individuals for whom health services are billed to the fund and to ensure that other coverage options are used~~utilized~~ fully before services are billed to the fund, **including procedures adopted ~~pursuant to~~under section 35~~ of this chapter~~**. The office shall review all claims billed to the fund to determine whether the patient is eligible for medical assistance under~~pursuant to~~ this chapter and whether any third party is financially responsible for the costs of care provided to the patient. In making these~~such~~ determinations, the office shall verify the insurance status of

Comment [SAN16]: Reference to current Medicaid statute re: procedures for ensuring that reimbursements are made only when there is no other payor.

each individual for whom a claim is made using all sources of data available to the office. The office shall refuse to allow payments or shall disallow payments to acute hospitals and community health centers for free care provided to individuals if reimbursement is available from other public or private sources.

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

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

the differences between the program administered by the office and the Title XVIII Medicare program, including the services and benefits covered, and, for purposesd of calculating the payment rates for covered hospital services, the office shall use a grouper and DRG relative weights that have been determined by the office, in consultation with the division of health care finance and policy and the Massachusetts Hospital Association, to reimburse acute hospitals at rates not less than the rates they are reimbursed by Medicare; the extent and duration of thesuch coverage; the populations served; **and any other adjustments as specified in regulations promulgated by the office.** ~~; and the assurance that providers will be held harmless at their current reimbursement levels~~. Following implementation of the provisions of this section, the office shall ensure that the ~~rates paid~~ **allowable reimbursement rates** ~~pursuant to~~under this section for health services provided to uninsured individuals shall not thereafter be less than rates of payment for comparable services under the Medicare program, taking into account the adjustments required by this section.

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

Comment [SAN17]: As drafted, this could be taken to mean hospitals should get same dollar amount as 06 or 07. See new protective language below.

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

(b) By April 1 of the year preceding the start of the fund fiscal year, the office shall, after consultation with the dDivision of hHealth cCare fFinance and pPolicy, and using the best data available, provide an estimate of the projected total reimbursable health services provided by acute hospitals and community health centers and emergency bad debt costs, the total funding available, and any projected shortfall after adjusting for reimbursement payments to community health centers. In the event that a shortfall in revenue exists in any fund fiscal year to cover projected costs for reimbursement of health services, the office shall allocate thatsaid shortfall in a manner**, including, but not limited to, the establishment of a graduated reimbursement system,** that reflects each hospital's proportional **financial** requirement for reimbursements from the fund, ~~in accordance with~~under regulations promulgated by the office, ~~**provided further that**~~**but in the 2~~**two**~~ years following implementation of this section any acute hospital receiving payments for reimbursable health services that, when measured on a comparable basis according to criteria established by the office, are not equivalent to reimbursements for free care received in the 2~~**two**~~ years preceding implementation of this section shall be eligible to receive supplemental funding from the Health Safety Net Trust Fund upon application to thatsaid office.**

Comment [SAN18]: Replaces hold harmless language in (a) 2 above—goal is to create smooth transition period to new reimbursement system by allowing hospitals to receive funds that allow them to be held harmless compared to previous reimbursement levels—but we don't want to measure these simply as a dollar amount.

(c) The division shall enter into interagency agreements with the department of revenue to verify income data for patients ~~who receive reimbursed~~ **whose** health care services **are reimbursed by the Health Safety Net Trust Fund** and to recover payments made by the fund for services provided to individuals who are ineligible ~~for~~ **to receive** reimburse~~d~~**able** health services or on whose behalf the fund has paid for emergency bad debt. The division shall promulgate regulations requiring acute hospitals to submit data that will enable the department of revenue to pursue recoveries from individuals who are ineligible for reimbursed health services and on whose behalf the fund has made payments to acute hospitals for emergency bad debt. Any amounts recovered shall be deposited in the Health Safety Net Trust Fund.

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

[effective date=Oct 1, 2007]

SECTION 25. [House 23]

Section 1 of chapter 118G of the General Laws, as appearing in the 2004 Official Edition, is hereby amended by striking out the definition of "Pool".

[effective date=Oct 1, 2007]

SECTION 26. [House 23A]

Said section 1 of said chapter 118G, as so appearing, is hereby further amended by striking out the definition of "Payments subject to surcharge".

[effective date=Oct 1, 2007]

SECTION 27. [NEW]

Said section 1 of said chapter 118G, as so appearing, is hereby further amended by striking out the definition of "Private sector charges".

[effective date=Oct 1, 2007]

SECTION 28. [NEW]

Said section 1 of said chapter 118G, as so appearing, is hereby further amended by striking out the definition of "Surcharge payor".

[effective date=Oct 1, 2007]

SECTION 29. [Senate 13C, 13D, 14, 15, 16, 18]

FREE RIDER PLACEHOLDER; SW&M TO SUPPLY LANGUAGE

SECTION 30. [House 24]

~~Clause (a) of S~~section 2 of said chapter 118G, as so appearing, is hereby amended by inserting after the **word** "services", in line 19, the following word:- and

SECTION 6A. Said section2 of said chapter 118G, as so appearing, is hereby further amended ~~and~~ by striking out clause (c) of the second paragraph.

[effective date=Oct 1, 2007]

SECTION 31. [House 25]

Section 3 of said chapter 118G, as so appearing, is hereby amended by striking out clause (g).

[effective date=Oct 1, 2007]

SECTION 32. [NEW]

Section 5 of said chapter 118G is hereby amended by striking out the first 2~~two~~ sentences and inserting in place thereof the following 2 sentences:—

Each acute hospital shall pay to the commonwealth an amount for the estimated expenses of the division and of the health safety net office established in section 56 of chapter 118E. This~~Such~~ amount shall be equal to the amount appropriated by the general court for the expenses of the division of health care finance and policy and of the health safety net office minus amounts collected from (1) filing fees, (2) fees and charges generated by the division's publication or dissemination of reports and information, (3) federal matching revenues received for these~~such~~ expenses or received retroactively for expenses of predecessor agencies, and (4), any amounts allocated from the health safety net trust fund, established in section 57 of chapter 118E for the purposes of administrative costs of the health safety net office, ~~provided that~~but a share of the revenues raised under this section shall be transferred to the safety net office.

[effective date=Oct 1, 2007]

Comment [SAN19]: Would continue to fund a portion of admin expenses via assessment on hospitals (changes current DHCFP language to include safety net care office)

SECTION 33. [House 27]

Section 18 of said chapter 118G is hereby repealed.

[effective date=Oct 1, 2007]

SECTION 34. [House 28]

Section 18A of said chapter 118G is hereby repealed.

[effective date=Oct 1, 2007]