SENATE . . . . . No. 588

By Mr. Moore, a petition (accompanied by bill, Senate, No. 588) of Richard T. Moore, Stephen M. Brewer, Brian A. Joyce, Bruce E. Tarr and Elizabeth A. Poirier for legislation to provide for the creation of the health care cost containment council. Health Care.

The Commonwealth of Massachusetts

In the Year Two Thousand and Three.

AN ACT PROVIDING FOR THE CREATION OF THE HEALTH CARE COST CONTAINMENT COUNCIL, FOR ITS POWERS AND DUTIES, FOR HEALTH CARE COST CONTAINMENT THROUGH THE COLLECTION AND DISSEMINATION OF DATA, AND FOR PUBLIC ACCOUNTABILITY OF HEALTH CARE COST.

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

SECTION 1. Short Title

This act shall be known and may be cited as the Health Care Cost Containment Act.

SECTION 2. Declaration

The Commonwealth finds that there exists in this State a major crisis because of the continuing escalation of costs for health care services. Because of the continuing escalation of costs, an increasingly large number of Massachusetts citizens have severely limited access to appropriate and timely health care. Increasing costs are also undermining the quality of health care services currently being provided. Further, the continuing escalation is negatively affecting the economy of this Commonwealth, is restricting new economic growth and is impeding the creation of new job opportunities in this Commonwealth. The continuing escalation of health care costs is attributable to a number of interrelated causes, including: (1) inefficiency in the present configuration of health care service systems and in their operation; (2) the present system of health care cost payments by third parties; (3) the increasing burden of indigent care which encourages cost shifting; and (4) the absence

of a concentrated and continuous effort in all segments of the health care industry to contain health care costs. Therefore, it is hereby declared to be the policy of the Commonwealth of Massachusetts to promote health care cost containment by creating an independent council to be known as the Health Care Cost Containment Council. It is the purpose of this legislation to promote the public interest by encouraging the development of competitive health care services, in which health care costs are contained and to assure that all citizens have reasonable access to quality health care. It is further the intent of this act to facilitate the continuing provision of quality, cost-effective health services throughout the Commonwealth by providing data and information to the purchasers and consumers of health care on both cost and quality of health care services, and to assure access to health care services. Nothing in this act shall prohibit a purchaser from obtaining from its third-party insurer, carrier or administrator, nor relieve said third-party insurer, carrier or administrator from the obligation of providing, on terms consistent with past practices, data previously provided to a purchaser pursuant to any existing or future arrangement, agreement or understanding.

SECTION 3. Creation

Chapter 118G of the General Laws as appearing in the 2000 Official Edition is hereby amended by striking out sections one through twenty-four and inserting in place the following sections:—

Section 1. Definitions

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

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

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

"Ambulatory service facility." A facility licensed in this Commonwealth, not part of a hospital, which provides medical, diag-

nostic or surgical treatment to patients not requiring hospitalization, including ambulatory surgical facilities, ambulatory imaging or diagnostic centers, birthing centers, freestanding emergency rooms and any other facilities providing ambulatory care which charge a separate facility charge. This term does not include the offices of private physicians or dentists, whether for individual or group practices.

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

"Carrier", an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B;

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

"Charge" or "rate." The amount billed by a provider for specific goods or services provided to a patient, prior to any adjustment for contractual allowances.

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

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

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

"Council." The Health Care Cost Containment Council.

"Covered services." Any health care services or procedures connected with episodes of illness that require either inpatient hospital care or major ambulatory service such as surgical, medical or major radiological procedures, including any initial and follow-up outpatient services associated with the episode of illness before, during or after inpatient hospital care or major ambulatory service. The term does not include routine outpatient services connected with episodes of illness that do not require hospitalization or major ambulatory service.

"Data source." A hospital; ambulatory service facility; physician; health maintenance organization, professional health services corporation; commercial insurer providing health or accident insurance; self-insured employer providing health or accident coverage or benefits for employees employed in the Commonwealth; administrator of a self-insured or partially self-insured health or accident plan providing covered services in the Commonwealth; any health and welfare fund that provides health or accident benefits or insurance pertaining to covered service in the Commonwealth; the Department of Medical Assistance for those covered services it purchases or provides through the medical assistance program and any other payor for covered services in the Commonwealth other than an individual.

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

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

"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.

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

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

"Employer", an employer as defined in section one of chapter one hundred and fifty-one A.

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

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

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

"Free care", unpaid hospital charges of medically necessary services to (1) patients deemed financially unable to pay, in whole or in part, for their care, pursuant to regulations of the division; (2) uninsured patients who receive emergency care in a hospital emergency room or who receive other hospital care associated with such emergency care services, for which the costs have not been collected after despite reasonable efforts in accordance with regulations of the division; or (3) patients in situations of medical hardship in which major expenditures for health care have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services cannot be paid, as determined by regulations of the division. For purposes of this section, "emergency care" shall include, but not be limited to: hospital services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity which include, but not be limited to, severe pain which pain reasonably appears may result in jeopardizing the patients' health if immediate medical attention is withheld; serious impairment to bodily functions or serious dysfunction of any bodily organ or part, examination or treatment for emergency medical condition; active labor in women; or any such other service rendered to the extent required pursuant to 42 USC 1395(dd).

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

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

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

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

"Health care services", supplies, care and services of medical, surgical, optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventative, rehabilitative, supportive or geriatric nature including, but not limited to, inpatient and outpatient acute hospital care and services; services provided by a community health center or by a sanatorium, as included in the definition of "hospital" in Title XVIII of the federal Social Security Act, and treatment and care compatible with such services or by a health maintenance organization.

"Health care facility." A general or special hospital, including tuberculosis and psychiatric hospitals, kidney disease treatment centers, including freestanding hemodialysis units, and ambulatory service facilities as defined in this section, and hospices, both profit and nonprofit, and including those operated by an agency of State or local government.

"Health care insurer." Any person, corporation or other entity that offers administrative, indemnity or payment services for

health care in exchange for a premium or service charge under a program of health care benefits, including, but not limited to, an insurance company, association or exchange issuing health insurance policies in this Commonwealth; hospital plan corporation; professional health services plan; health maintenance organization; preferred provider organization; fraternal benefit societies; beneficial societies; and third-party administrators; but excluding employers, labor unions or health and welfare funds jointly or separately administered by employers or labor unions that purchase or self-fund a program of health care benefits for their employees or members and their dependents.

"Health maintenance organization." An organized system licensed pursuant to chapter 176G.

"Hospital." An institution, licensed in this Commonwealth, which is a general, tuberculosis, mental, chronic disease or other type of hospital, or kidney disease treatment center, whether profit or nonprofit, and including those operated by an agency of State or local government.

"Health insurance company", a company as defined in section one of chapter one hundred and seventy-five which engages in the business of health insurance.

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

"Health maintenance organization", a company which provides or arranges for the provision of health care services to enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum as further defined in section one of chapter one hundred and seventy-six G.

"Hospital", any hospital licensed under section fifty-one of chapter one hundred and eleven, the teaching hospital of the University of Massachusetts Medical School and any psychiatric facility licensed under section nineteen of chapter nineteen.

"Hospital agreement", an agreement between a nonprofit hospital service corporation and the hospital signatory thereto approved by the division under section five of chapter one hundred and seventy-six A.

"Hospital service corporation", a corporation established for the purpose of operating a nonprofit hospital service plan as provided in chapter one hundred and seventy-six A.

"Indigent care." The actual costs, as determined by the council, for the provision of appropriate health care, on an inpatient or outpatient basis, given to individuals who cannot pay for their care because they are above the medical assistance eligibility levels and have no health insurance or other financial resources which can cover their health care.

"Major ambulatory service." Surgical or medical procedures, including diagnostic and therapeutic radiological procedures, commonly performed in hospitals or ambulatory service facilities, which are not of a type commonly performed or which cannot be safely performed in physicians' offices and which require special facilities such as operating rooms or suites or special equipment such as fluoroscopic equipment or computed tomographic scanners, or a postprocedure recovery room or short-term convalescent room.

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

"Medical procedure incidence variations." The variation in the incidence in the population of specific medical, surgical and radiological procedures in any given year, expressed as a deviation from the norm, as these terms are defined in the classical statistical definition of "variation," "incidence," "deviation" and "norm."

"Medically indigent" or "indigent." The status of a person as described in the definition of indigent care.

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

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

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

"Medical service corporation", a corporation established for the purpose of operating a nonprofit medical service plan as provided in chapter one hundred and seventy-six B.

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

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

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

"Payment." The payments that providers actually accept for their services, exclusive of charity care, rather than the charges they bill.

"Payor." Any person or entity, including, but not limited to, health care insurers and purchasers, that make direct payments to providers for covered services.

"Physician." An individual licensed under the laws of this Commonwealth to practice medicine and surgery

"Pool", the uncompensated care pool established pursuant to section 18.

"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 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 publicly aided patients, free care and bad debt.

"Preferred provider organization." Any arrangement between a health care insurer and providers of health care services which specifies rates of payment to such providers which differ from their usual and customary charges to the general public and which encourage enrollees to receive health services from such providers.

"Provider." A hospital, an ambulatory service facility or a physician.

"Provider quality." The extent to which a provider renders care that, within the capabilities of modern medicine, obtains for patients medically acceptable health outcomes and prognoses, adjusted for patient severity, and treats patients compassionately and responsively.

"Provider service effectiveness." The effectiveness of services rendered by a provider, determined by measurement of the medical outcome of patients grouped by severity receiving those services.

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

"Public payer-dependent non-acute hospital", any non-acute hospital that (1) was certified by the Secretary of the United States Department of Health and Human Services as participating in the federal medicare program pursuant to clause (iv) of 42 USC section 1395ww (d)(1)(B) on January first, nineteen hundred and ninety-six; (2) is not owned by the commonwealth; and (3) exhibits a payor mix in which a minimum of fifteen per cent of such hospital's gross patient service revenue, as reported on the RSC-403 for hospital fiscal year nineteen hundred and ninety-four, was attributable to Title XIX of the federal Social Security

Act. Such term does not include a hospital that was reimbursed for services provided to individuals entitled to medical assistance under chapter one hundred and eighteen E for fiscal year nineteen hundred and ninety-six pursuant to a contract between the hospital and the division of medical assistance.

"Purchaser." All corporations, labor organizations and other entities that purchase benefits which provide covered services for their employees or members, either through a health care insurer or by means of a self-funded program of benefits, and a certified bargaining representative that represents a group or groups of employees for whom employers purchase a program of benefits which provide covered services, but excluding entities defined in this section as "health care insurers."

"Raw data" or "data." Data collected by the council under section 6 in the form initially received. No data shall be released by the council except as provided for in section 11.

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

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

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

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

"Severity." In any patient, the measureable degree of the potential for failure of one or more vital organs.

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

"Sole community provider", any acute hospital which qualifies as a sole community provider under medicare regulations or under

regulations promulgated by the division, which regulations shall consider factors including, but not limited to, such as isolated location, weather conditions, travel conditions, percentage of Medicare, Medicaid and free care provided and the absence of other reasonably accessible hospitals in the area. Such hospitals shall include those which are located more than twenty-five miles from other such hospitals in the commonwealth and which provide services for at least sixty percent of their primary service area.

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

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

"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; provided, however, that the terms "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 pursuant to chapter 152.

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

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

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

Section 2. Health Care Cost Containment Council.

(a) Establishment.— There is hereby established an independent council to be known as the Health Care Cost Containment Council.

(b) Composition.— The council shall consist of 13 voting members, composed of and appointed in accordance with the following:

a. The Secretary of the Executive Office of Health and Human Services;

b. The Commissioner of the Division of Insurance;

c. The Commissioner of the Division of Medical Assistance;

d. Two representatives of the business community, at least one of whom represents small business, who are purchasers of health care as defined in section 3, none of which is primarily involved in the provision of health care or health insurance, one of which shall be appointed by the President of the Senate and one of which shall be appointed by the Speaker of the House of Representatives from a list of seven qualified persons recommended by the Associated Industries Association of which three nominees shall be representatives of small business;

e. Two representatives of organized labor, one of which shall be appointed by the President of the Senate and one of which shall be appointed by the Speaker of the House of Representatives from a list of five qualified persons recommended by the Massachusetts AFL-CIO;

f. One representative of consumers who is not primarily involved in the provision of health care or health care insurance, appointed by the Governor from a list of three qualified persons recommended jointly by the President of the Senate and the Speaker of the House;

g. One representative of hospitals, appointed by the Governor from a list of three qualified hospital representatives recommended by the Massachusetts Hospital Association. The representative under this paragraph may appoint a delegate to act for the representative only at meetings of committees as provided for in subsection (f)

h. One representative of physicians, appointed by the Governor from a list of three qualified physician representatives recommended by the Massachusetts Medical Society. The representative under this paragraph may appoint a delegate to act for the repre-

sentative only at meetings of committees as provided for in subsection (f);

i. One representative of nurses, appointed by the Governor from a list of three qualified persons recommended by the Massachusetts Nurses Association and the Massachusetts Organization of Nurses Executives;

j. One representative from a health maintenance organization, appointed by the Governor from a list of three qualified persons recommended by the Massachusetts Association of Health Plans; and

k. One representative of a carrier, appointed by the Governor from a list of three qualified persons recommended by the Massachusetts Association of Health Plans.

l. In the case of each appointment to be made from a list supplied by a specified organization, it is incumbent upon that organization to consult with and provide a list that reflects the input of other equivalent organizations representing similar interests. Each appointing authority will have the discretion to request additions to the list originally submitted. Additional names will be provided not later than 15 days after such request. Appointments shall be made by the appointing authority no later than 90 days after receipt of the original list. If, for any reason, any specified organization supplying a list should cease to exist, then the respective appointing authority shall specify a new equivalent organization to fulfill the responsibilities of this act.

(c) Chairs.— The members shall annually elect, by a majority vote of the members, a chairperson and a vice chairperson of the council from among the business and labor representatives on the council.

(d) Quorum.— Seven members shall constitute a quorum for the transaction of any business, and the act by the majority of the members present at any meeting in which there is a quorum shall be deemed to be the act of the council.

(e) Meetings.— All meetings of the council shall be advertised and conducted pursuant to Chapter 30A unless otherwise provided in this section.

a. The council shall meet at least once every two months, and may provide for special meetings as it deems necessary. Meeting dates shall be set by a majority vote of the members of the council or by the call of the chairperson upon seven days' notice to all council members.

b. All meetings of the council shall be publicly advertised, as provided for in this subsection, and shall be open to the public, 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.

c. The council shall file a schedule of its meetings with the Secretary of State and shall publish a schedule of its meetings in at least two newspapers, one newspaper in general circulation in the Commonwealth. Such notice shall be published and filed at least once in each calendar quarter and shall list the schedule of meetings of the council to be held in the subsequent calendar quarter. Such notice shall specify the date, time and place of the meeting and shall state that the council's meetings are open to the general public, except that no such notice shall be required for executive sessions of the council.

d. All action taken by the council shall be taken in open public session, and action of the council shall not be taken except upon the affirmative vote of a majority of the members of the council present during meetings at which a quorum is present.

(f) Bylaws.— The council shall adopt bylaws, not inconsistent with this act, and may appoint such committees or elect such officers subordinate to those provided for in subsection (c) as it deems advisable. The council shall provide for the approval and participation of additional delegates appointed under subsection b(g) and (h) so that each organization represented by delegates under those paragraphs shall not have more than one vote on any committee to which they are appointed. The council shall also appoint a technical advisory group which shall, on an ad hoc basis, respond to issues presented to it by the council or committees of the council and shall make recommendations to the council. The technical advisory group shall include physicians, researchers and biostatisticians. In appointing the technical advisory group, the council shall consult with, and take nominations from, the representatives of the Massachusetts Hospital Association, the Massachusetts Medical Society or other like organizations. At its discretion, nominations shall be approved by the executive committee of the council. If the subject matter of any project exceeds the expertise of the technical advisory group, physicians in appropriate specialties who possess current knowl-

edge of the issue under study may be consulted. The technical advisory group shall also review the availability and reliability of severity of illness measurements as they relate to small hospitals and psychiatric, rehabilitation and children's hospitals and shall make recommendations to the council based upon this review.

(g) Compensation.— 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. Said expenses may include reimbursement of travel and living expenses while engaged in council business.

(h) Terms.—

a. The terms of the Secretary of the Executive Office of Health and Human Services, the Commissioner of the Division Medical Assistance and the Commissioner of the Division of Insurance shall be concurrent with their holding of public office. The nine appointed council members shall each serve for a term of three years and shall continue to serve thereafter until their successor is appointed, except that, of the members first appointed:

i. One of the representatives of business and the representative of consumers shall serve for a term to expire on June 30 of the year following their appointment.

ii. One of the representatives of organized labor and the representative of a carrier shall serve for a term to expire on June 30 of the second year following their appointment.

iii. The other representatives of business and organized labor and the representatives of hospitals, physicians and health maintenance organizations shall serve for a term to expire on June 30 of the third year following their appointment.

b. Vacancies on the council shall be filled in the same manner in which they were originally designated under subsection (b), within 60 days of the vacancy, except that when vacancies occur among the representatives of business or organized labor, two nominations shall be submitted by the organization specified in subsection (b) for each vacancy on the council. If the officer required in subsection (b) to make appointments to the council fails to act within 60 days of the vacancy, the council chairperson may appoint one of the persons recommended for the vacancy, until the appointing authority makes the appointment.

c. A member may be removed for just cause by the appointing authority after recommendation by a vote of at least 8 members of the council.

(i) Commencement of Operations.

a. Within 60 days after the effective date of this act, each organization or individual required to submit a list of recommended persons to the Governor, the President of the Senate or the Speaker of the House of Representatives under subsection (b) shall submit said list.

b. Within 90 days of the effective date of this act, the Governor, the President of the Senate and the Speaker of the House of Representatives shall make all of the appointments called for in subsection (b), and the council shall begin operations immediately following these appointments.

(j) Subsequent appointments.-Submission of lists of recommended persons and appointments of council members for the second and succeeding terms shall be made in the same manner as prescribed in subsection (b), except that:

a. Organizations required under subsection (b) to submit lists of recommended persons shall do so at least 60 days prior to expiration of the council members' terms.

b. The officer required under subsection (b) to make appointments to the council shall make said appointments at least 30 days prior to expiration of the council members' terms. If the appointments are not made within the specified time, the council chairperson may make interim appointments from the lists of recommended individuals. An interim appointment shall be valid only until the appropriate officer under subsection (b) makes the required appointment. Whether the appointment is by the required officer or by the chairperson of the council, the appointment shall become effective immediately upon expiration of the incumbent member's term.

(k) Appointments of acting councilors.-Should any organization or individual fail to submit a list of recommended persons as required under subsection (b) within the time limits in subsection (i) or (j), the officer designated to make the appointment under subsection (b) shall appoint as many acting councilors as required under subsection (b) until such time as the list of recommended persons is submitted by the original organization as required in subsection (b).

Section 3. Powers and duties of the council.

(a) General powers.—The council shall exercise all powers necessary and appropriate to carry out its duties, including the following:

a. To employ an executive director, investigators and other staff necessary to comply with the provisions of this act and regulations promulgated thereunder, to employ or retain legal counsel, and to engage professional consultants, as it deems necessary to the performance of its duties. Any consultants, other than sole source consultants, engaged by the council shall be selected in accordance with the provisions for contracting with vendors set forth in section 12.

b. To fix the compensation of all employees and to prescribe their duties. Notwithstanding the independence of the council under section 2(a), employees under this paragraph shall be deemed employees of the commonwealth for the purpose of benefits provided for under Chapter 32 and 32A of the General Laws.

c. To make and execute contracts and other instruments, including those for purchase of services and purchase or leasing of equipment and supplies, necessary or convenient to the exercise of the powers of the council. Any such contract shall be let only in accordance with the provision for contracting with vendors set forth in section 12.

d. To enter into agreement or transactions with any federal, state or municipal agency or other public institution or with any private individual, partnership, firm, corporation, association or other entity;

e. To acquire, own, hold, dispose of, and encumber personal property and to lease real property in the exercise of its powers and the performance of its duties;

f. To maintain a prudent level of reserve funds to protect the solvency of any trust funds under the operations and control of the council;

g. To conduct examinations and investigations, to conduct audits, pursuant to the provisions of subsection (c), and to hear testimony and take proof, under oath or affirmation, at public or private hearings, on any matter necessary to its duties.

h. To do all things necessary to carry out its duties under the provisions of this act.

(b) Rules and regulations.—The council may adopt and amend rules and regulations in accordance with chapter 30A for the administration of its duties and power and to effectuate the provision and purposes of this act.

(c) Audit powers.—The council shall have the right to independently audit all information required to be submitted by data sources as needed to corroborate the accuracy of the submitted data, pursuant to the following:

a. Audits of information submitted by providers or health care insurers shall be performed on a sample and issue-specific basis, as needed by the council, and shall be coordinated, to the extent practicable, with audits performed by the Commonwealth. All health care insurers and providers are hereby required to make those books, records of accounts and any other data needed by the auditors available to the council at a convenient location within 30 days of a written notification by the council.

b. Audits of information submitted by purchasers shall be performed on a sample basis, unless there exists reasonable cause to audit specific purchasers, but in no case shall the council have the power to audit financial statements of purchasers.

c. All audits performed by the council shall be performed at the expense of the council.

(d) General duties and functions. The council is hereby authorized to and shall perform the following duties and functions:

a. Develop a computerized system for the collection, analysis and dissemination of data. The council may contract with a vendor who will provide such data processing services. The council shall assure that the system will be capable of processing all data required to be collected under this act. Any vendor selected by the council shall be selected in accordance with the provisions of section 12, and said vendor shall relinquish any and all proprietary rights or claims to the database created as a result of implementation of the data processing system.

b. Establish a Massachusetts Uniform Claims and Billing Form for all data sources and all providers that shall be utilized and maintained by all data sources and all providers for all services covered under this act.

c. Collect and disseminate data, as specified in section 4, and other information from data sources to which the council is enti-

tled, prepared according to formats, time frames and confidentiality provisions as specified in sections 4 and 6, and by the council.

d. Adopt and implement a methodology to collect and disseminate data reflecting provider quality and provider service effectiveness pursuant to section 4 and to continuously study quality of care systems.

e. Subject to the restrictions on access to raw data set forth in section 6, issue special reports and make available raw data as defined in section 1 to any purchaser requesting it. Sale by any recipient or exchange or publication by a recipient, other than a purchaser, of raw council data to other parties without the express written consent of, and under terms approved by, the council shall be unauthorized use of data pursuant to section 6(c).

f. On an annual basis, file with the General Court on the first Wednesday in November, a list of all the raw data reports it has prepared under section 6(f) and a description of the data obtained through each computer-to-computer access it has provided under section 6(f) and of the names of the parties to whom the council provided the reports or the computer-to-computer access during the previous month.

g. Promote competition in the health care and health insurance markets.

h. Assure that the use of council data does not raise access barriers to care.

i. Make annual reports to the General Court on the first Wednesday in March on the rate of increase in the cost of health care in the Commonwealth and the effectiveness of the council in carrying out the legislative intent of this act. In addition, the council may make recommendations on the need for further health care cost containment legislation. The council shall also make annual reports to the General Court on the quality and effectiveness of health care and access to health care for all citizens of the Commonwealth.

j. Adopt, within one year, a model patient itemized statement for all providers, which itemizes all charges for services, equipment, supplies and medicine, designed to be more understandable than current patient bills. Each provider shall be required to utilize said model patient itemized statement for covered services within 90 days of

adoption of said form by the council. Such model patient itemized statements shall be written in language that is understandable to the average person and be presented to each patient upon discharge from a health care facility or provision of patient services or within a reasonable time thereafter. Patients may request a copy of their Massachusetts Uniform Claims and Billing Form; and, upon request, the provider shall furnish this form to the patient within 30 days.

k. Conduct studies and publish reports thereon analyzing the effects that non-inpatient, alternative health care delivery systems have on health care costs. These systems shall include, but not be limited to: health maintenance organizations; preferred provider organizations; primary health care facilities; home health care; attendant care; ambulatory service facilities; freestanding emergency centers; birthing centers; and hospice care. These reports shall be submitted to the General Court and shall be made available to the public.

l. Conduct studies and make reports concerning the utilization of experimental and nonexperimental transplant surgery and other highly technical and experimental procedures, including costs and mortality rates.

m. Review and comment upon all capital expenditure projects requiring a determination of need pursuant to the provisions of section twenty-five of chapter one hundred and eleven of the General Laws, including, but not limited to, less costly or more effective alternative financing methods for such projects; the immediate and long-term financial feasibility of such projects; the probable impact of the project on costs of and charges for services; and the availability of funds for capital and operating needs. The council shall transmit to the department of public health its written recommendations on each project, which shall become part of the written record compiled by said department during its review of such project. The council executive director shall appear and comment on any application for a determination of need where a public hearing is required pursuant to the provisions of said section twenty-five C of said chapter. To carry out the purposes of this paragraph, the council executive director shall act as a liaison with said department.

n. To contract pursuant to section 12, with a third part administrator to administer the uncompensated care pool established by section 22.

o. To oversee the health finance unit established pursuant to section 14.

SECTION 4. Data submission and collection.

(a) Submission of data.—The council is hereby authorized to collect and data sources are hereby required to submit, upon request of the council, all data required in this section, according to uniform submission formats, coding systems and other technical specifications necessary to render the incoming data substantially valid, consistent, compatible and manageable using electronic data processing according to data submission schedules, such schedules to avoid, to the extent possible, submission of identical data from more than one data source, established and promulgated by the council in regulations pursuant to its authority under section 3(b). If payor data is requested by the council, it shall, to the extent possible, be obtained from primary payor sources.

(b) Massachusetts Uniform Claims and Billing Form.—The council shall adopt, within 180 days of the commencement of its operations pursuant to section 2(i), a Massachusetts Uniform Claims and Billing Form format. The council shall furnish said claims and billing form format to all data sources, and said claims and billing form shall be utilized and maintained by all data sources for all services covered by this act. The Massachusetts Uniform Claims and Billing Form shall consist of the Uniform Hospital Billing Form UB-82/HCFA-1450, and the HCFA-1500, or their successors, as developed by the National Uniform Billing Committee, with additional fields as necessary to provide all of the data set forth in subsections (c) and (d).

(c) Data elements.—For each covered service performed in Massachusetts, the council shall be required to collect the following data elements:

a. uniform patient identifier, continuous across multiple episodes and providers;

b. patient date of birth;

c. patient sex;

d. patient race, consistent with the method of collection of race/ethnicity data by the United States Bureau of the Census and the United States Standard Certificates of Live Birth and Death;

e. patient ZIP Code number;

f. date of admission;
g. date of discharge;
h. principal and up to five secondary diagnoses by standard code, including external cause code;
i. principal procedure by council-specified standard code and date;
j. up to three secondary procedures by council- specified standard codes and dates;
k. uniform health care facility identifier, continuous across episodes, patients and providers;
l. uniform identifier of admitting physician, by unique physician identification number established by the council, continuous across episodes, patients and providers;
m. uniform identifier of consulting physicians, by unique physician identification number established by the council, continuous across episodes, patients and providers;
n. total charges of health care facility, segregated into major categories, including, but not limited to, room and board, radiology, laboratory, operating room, drugs, medical supplies and other goods and services according to guidelines specified by the council;
o. actual payments to health care facility, segregated, if available, according to the categories specified in paragraph n;
p. charges of each physician or professional rendering service relating to an incident of hospitalization or treatment in an ambulatory service facility;
q. actual payments to each physician or professional rendering service pursuant to paragraph p;
r. uniform identifier of primary payor;
s. ZIP Code number of facility where health care service is rendered;
t. uniform identifier for payor group contract number;
u. patient discharge status; and
v. provider service effectiveness and provider quality pursuant to section 3(d)(d) and subsection (d).

(d) Provider quality and provider service effectiveness data elements.—In carrying out its duty to collect data on provider quality and provider service effectiveness under section 3(d)(d) and subsection (c)(v), the council shall define a methodology to measure provider service effectiveness which may include additional data

elements to be specified by the council sufficient to carry out its responsibilities under section 3(d)(d). The council may adopt a nationally recognized methodology of quantifying and collecting data on provider quality and provider service effectiveness until such time as the council has the capability of developing its own methodology and standard data elements. The council shall include in the Massachusetts Uniform Claims and Billing Form a field consisting of the data elements required pursuant to subsection (c)(v) to provide information on each provision of covered services sufficient to permit analysis of provider quality and provider service effectiveness within 180 days of commencement of its operations pursuant to section 2.

(e) Reserve field utilization and addition or deletion of data elements.—The council shall include in the Massachusetts Uniform Claims and Billing Form a reserve field. The council may utilize the reserve field by adding other data elements beyond those required to carry out its responsibilities under section 3(d)(c) and (d) and subsections (c) and (d), or the council may delete data elements from the Massachusetts Uniform Claims and Billing Form only by a majority vote of the council and only pursuant to the following procedure:

a. The council shall obtain a cost-benefit analysis of the proposed addition or deletion, which shall include the cost to data sources of any proposed additions.

b. The council shall publish notice of the proposed addition or deletion, along with a copy or summary of the cost-benefit analysis, with the General Court, and such notice shall include provision for a 60-day comment period.

c. The council may hold additional hearings or request such other reports as it deems necessary and shall consider the comments received during the 60-day comment period and any additional information gained through such hearings or other reports in making a final determination on the proposed addition or deletion.

(f) Other data required to be submitted.-Providers are hereby required to submit and the council is hereby authorized to collect, in accordance with submission dates and schedules established by the council, the following additional data, provided such data is not available to the council from public records:

a. Audited annual financial reports of all hospitals and ambulatory service facilities providing covered services as defined in section 1.

b. The Medicare cost report OMB Form 2552 or equivalent Federal form, or the AG-12 form for Medical Assistance or successor forms, whether completed or partially completed, and including the settled Medicare cost report and the certified AG-12 form.

c. Additional data, including, but not limited to, data which can be used to provide at least the following information:

i. the incidence of medical and surgical procedures in the population for individual providers;

ii. physicians who provide covered services and accept medical assistance patients;

iii. physicians who provide covered services and accept Medicare assignment as full payment;

iv. mortality rates for specified diagnoses and treatments, grouped by severity, for individual providers;

v. rates of infection for specified diagnoses and treatments, grouped by severity, for individual providers;

vi. morbidity rates for specified diagnoses and treatments, grouped by severity, for individual providers;

vii. readmission rates for specified diagnoses and treatments, grouped by severity, for individual providers; and rate of incidence of postdischarge professional care for selected diagnoses and procedures, grouped by severity, for individual providers.

d. Any other data the council requires to carry out its responsibilities pursuant to section 3(d).

(g) Allowance for clarification or dissents.—The council shall maintain a file of written statements submitted by data sources who wish to provide an explanation of data that they feel might be misleading or misinterpreted. The council shall provide access to such file to any person and shall, where practical, in its reports and data files indicate the availability of such statements. When the council agrees with such statements, it shall correct the appropriate data and comments in its data files and subsequent reports.

(h) Availability of data.—Nothing in this act shall prohibit a purchaser from obtaining from its health care insurer, nor relieve said health care insurer from the obligation of providing said pur-

chaser, on terms consistent with past practices, data previously provided or additional data not currently provided to said purchaser by said health care insurer pursuant to any existing or future arrangement, agreement or understanding.

SECTION 5. Data dissemination and publication.

(a) Public reports.—Subject to the restrictions on access to council data set forth in section 6 and utilizing the data collected under section 4 as well as other data, records and matters of record available to it, the council shall prepare and issue reports to the General Court and to the general public, according to the following provisions:

a. The council shall, for every provider within the Commonwealth and within appropriate regions and subregions within the Commonwealth and for those inpatient and outpatient services which, when ranked by order of frequency, account for at least 65% of all covered services and which, when ranked by order of total payments, account for at least 65% of total payments, prepare and issue reports that at least provide information on the following:

i. Comparisons among all providers of payments received, charges, population-based admission or incidence rates, and provider service effectiveness, such comparisons to be grouped according to diagnosis and severity, and to identify each provider by name and type or specialty.

ii. Comparisons among all providers, except physicians, of inpatient and outpatient charges and payments for room and board, ancillary services, drugs, equipment and supplies and total services, such comparisons to be grouped according to provider quality and provider service effectiveness and according to diagnosis and severity, and to identify each health care facility by name and type.

iii. Until and unless a methodology to measure provider quality and provider service effectiveness pursuant to sections 3(d)(d) and 4(c) and (d) is available to the council, comparisons among all providers, grouped according to diagnosis, procedure and severity, which identify facilities by name and type and physicians by name and specialty, of charges and payments received, readmission rates, mortality rates, morbidity rates and infection rates.

Following adoption of the methodology specified in sections 3(d)(d) and 4(c) and (d), the council may, at its discretion, discontinue publication of this component of the report.

iv. The incidence rate of selected medical or surgical procedures, the provider service effectiveness and the payments received for those providers, identified by the name and type or specialty, for which these elements vary significantly from the norms for all providers.

b. In preparing its reports under paragraph a, the council shall ensure that factors that have the effect of either reducing provider revenue or increasing provider costs, and other factors beyond a provider's control which reduce provider competitiveness in the market place, are explained in the reports. It shall also ensure that any clarifications and dissents submitted by individual providers under section 4(g) are noted in any reports that include release of data on that individual provider.

c. The council shall, for all providers within the Commonwealth and within appropriate regions and subregions within the Commonwealth, prepare and issue quarterly reports that at least provide information on the:

i. number of physicians, by specialty, on the staff of each hospital or ambulatory service facility and those physicians on the staff that accept Medicare assignment as full payment and that accept Medical Assistance patients.

d. The council shall publish all reports required in this section with the General Court and shall publish, in at least one newspaper of general circulation in each subregion within the Commonwealth, reports on the providers in that subregion and subregions adjacent to it. In addition, the council shall advertise annually the availability of these reports and the charge for duplication and in at least one newspaper of general circulation in each subregion within the Commonwealth at least once in each calendar quarter.

(b) Raw data reports and computer access to council data.- The council shall provide special reports derived from raw data and a means for computer-to-computer access to its raw data to any purchaser, pursuant to section 6(f). The council shall provide such reports and computer-to-computer access, at its discretion, to other parties, pursuant to section 6(g). The council shall provide

these special reports and computer-to-computer access in as timely a fashion as the council's responsibilities to publish the public reports required in this section will allow. Any such provision of special reports or computer-to-computer access by the council shall be made only subject to the restrictions on access to raw data set forth in section 6(b) and only after payment for costs of preparation or duplication pursuant to section 6(f) or (g).

SECTION 6. Access to council data.

(a) Public access.—The information and data received by the council shall be utilized by the council for the benefit of the public and public officials. Subject to the specific limitations set forth in this section, the council shall make determinations on requests for information in favor of access.

a. Outreach programs.—The council shall develop and implement outreach programs designed to make its information understandable and usable to purchasers, providers, other Commonwealth agencies and the general public. The programs shall include efforts to educate, through pamphlets, booklets, seminars and other appropriate measures and to facilitate making more informed health care choices.

(b) Limitations on access.—Unless specifically provided for in this act, neither the council nor any contracting system vendor shall release and no data source, person, member of the public or other user of any data of the council shall gain access to:

a. Any raw data of the council that does not simultaneously disclose payment, as well as provider quality and provider service effectiveness pursuant to sections 3(d)(d) and 4(d) or 5(a)(a)(iii).

b. Any raw data of the council which could reasonably be expected to reveal the identity of an individual patient.

c. Any raw data of the council which could reasonably be expected to reveal the identity of any purchaser, as defined in section 1, other than a purchaser requesting data on its own group or an entity entitled to said purchaser's data pursuant to subsection (f).

d. Any raw data of the council relating to actual payments to any identified provider made by any purchaser, except that this provision shall not apply to access by a purchaser requesting data on the group for which it purchases or otherwise provides covered

services or to access to that same data by an entity entitled to the purchaser's data pursuant to subsection (f).

e. Any raw data disclosing discounts or differentials between payments accepted by providers for services and their billed charges obtained by identified payors from identified providers unless comparable data on all other payors is also released and the council determines that the release of such information is not prejudicial or inequitable to any individual payor or provider or group thereof. In making such determination the council shall consider that it is primarily concerned with the analysis and dissemination of payments to providers, not with discounts.

(c) Unauthorized use of data.—Any person who knowingly releases council data violating the patient confidentiality, actual payments, discount data or raw data safeguards set forth in this section to an unauthorized person commits a misdemeanor of the first degree and shall, upon conviction, be sentenced to pay a fine of $10,000 or to imprisonment for not more than five years, or both. An unauthorized person who knowingly receives or possesses such data commits a misdemeanor.

(d) Unauthorized access to data.—Should any person inadvertently or by council error gain access to data that violates the safeguards set forth in this section, the data must immediately be returned, without duplication, to the council with proper notification.

(e) Public access to records.—All public reports prepared by the council shall be public records and shall be available to the public for a reasonable fee.

(f) Access to raw council data by purchasers.-Pursuant to sections 3(d)(e) and 5(b) and subject to the limitations on access set forth in subsection (b) in this section, the council shall provide access to its raw data to purchasers in accordance with the following procedure:

a. Special reports derived from raw data of the council shall be provided by the council to any purchaser requesting such reports.

b. A means to enable computer-to-computer access by any purchaser to raw data of the council as defined in section 1 shall be developed, adopted and implemented by the council, and the council shall provide such access to its raw data to any purchaser upon request.

c. In the event that any employer obtains from the council, pursuant to paragraph a or (b), data pertaining to its employees and their dependents for whom said employer purchases or otherwise provides covered services as defined in section 1 and who are represented by a certified collective bargaining representative, said collective bargaining representative shall be entitled to that same data, after payment of fees as specified in paragraph d. Likewise, should a certified collective bargaining representative obtain from the council, pursuant to paragraph (a) or (b), data pertaining to its members and their dependents who are employed by and for whom covered services are purchased or otherwise provided by any employer, said employer shall be entitled to that same data, after payment of fees as specified in paragraph d.

d. In providing for access to its raw data, the council shall charge the purchasers which originally obtained such access a fee sufficient to cover its costs to prepare and provide special reports requested pursuant to paragraph a or to provide computer-to-computer access to its raw data requested pursuant to paragraph b. Should a second or subsequent party or parties request this same information pursuant to paragraph c, the council shall charge said party a reasonable fee.

(g) Access to raw council data by other parties.—Subject to the limitations on access to raw council data set forth in subsection (b) in this section, the council may, at its discretion, provide special reports derived from its raw data or computer-to- computer access to parties other than purchasers. The council shall publish regulations that set forth the criteria and the procedure it shall use in making determinations on such access, pursuant to the powers vested in the council in section 2. In providing such access, the council shall charge the party requesting the access a reasonable fee.

SECTION 7. Special studies and reports.

(a) Special studies.—The council may publish or contract for publication of special studies. Any special study so published shall become a public document.

(b) Special reports.—a. Any council may study and issue a report on the special medical needs, demographic characteristics, access or lack thereof to health care services and need for financing of health care services of:

i. Senior citizens, particularly low-income senior citizens, senior citizens who are members of minority groups and senior citizens residing in low-income urban or rural areas.

ii. Low-income urban or rural areas.

iii. Minority communities.

iv. Women.

v. Children.

vi. Unemployed workers.

vii. Veterans.

b. The reports shall include information on the current availability of services to these targeted parts of the population, and whether access to such services has increased or decreased over the past ten years, and specific recommendations for the improvement of their primary care and health delivery systems, including disease prevention and comprehensive health care services. The council may also study and report on the effects of using prepaid, capitated or HMO health delivery systems as ways to promote the delivery of primary health care services to the underserved segments of the population enumerated above.

c. The council may study and report on the short- term and long-term fiscal and programmatic impact on the health care consumer of changes in ownership of hospitals from nonprofit to profit, whether through purchase, merger or the like. The department may also study and report on factors, which have the effect of either reducing provider revenue or increasing provider cost, and other factors beyond a provider's control, which reduce provider competitiveness in the marketplace, are explained in the reports.

SECTION 8. Enforcement; penalty.

(a) Compliance enforcement.—The council shall have standing to bring an action in law or in equity through private counsel in any court of common pleas to enforce compliance with any provision of this act, except section 7, or any requirement or appropriate request of the council made pursuant to this act. In addition, the Attorney General is authorized and shall bring any such enforcement action in aid of the council in any court of common pleas at the request of the council in the name of the Commonwealth.

(b) Penalty.—Any person who fails to supply data pursuant to section 4 commits a misdemeanor and shall, upon conviction, be

sentenced to pay a fine not to exceed $1,000. Each day on which the required data is not submitted constitutes a separate offense under this paragraph. Any person who, after being sentenced under paragraph (a), fails to supply data pursuant to section 4 commits a misdemeanor and shall, upon conviction, be sentenced to pay a fine of $10,000 or to imprisonment for not more than five years, or both. In addition, the appropriate licensing authority may suspend or revoke, after an adjudicatory proceeding in accordance with chapter thirty A, the license of any provider of services that knowingly fails to file with the council data, statistics, schedules or other information required by this section or by any regulation of the council or that knowingly falsifies the same.

SECTION 9. Research and demonstration projects.

The council shall actively encourage research and demonstrations to design and test improved methods of assessing provider quality, provider service effectiveness and efficiency. To that end, provided that no data submission requirements in a mandated demonstration may exceed the current reserve field on the Massachusetts Uniform Claims and Billing Form, the council may:

a. Authorize contractors engaged in health services research selected by the council, pursuant to the provisions of section 12, to have access to the council's raw data files, providing such entities assume any contractual obligations imposed by the council to assure patient identity confidentiality.

b. Place data sources participating in research and demonstrations on different data submission requirements from other data sources in this Commonwealth.

c. Require data source participation in research and demonstration projects when this is the only testing method the council determines is promising.

SECTION 10. Grievances and Hearings.

(a) Procedures and requirements.—Pursuant to its powers to publish regulations under section 3(b) and with the requirements of this section, the council is hereby authorized and directed to establish procedures and requirements for the filing, hearing and adjudication of grievances against the council of any data source. Such procedures and requirements shall be published with the General Court.

(b) Claims; hearings.—Grievance claims of any data source shall be submitted to the council or to a third party designated by the council, and the council or the designated third party shall convene a hearing, if requested, and adjudicate the grievance.

SECTION 11. Antitrust provisions.

Persons or entities required to submit data or information under this act or receiving data or information from the council in accordance with this act are declared to be acting pursuant to State requirements embodied in this act and shall be exempt from antitrust claims or actions grounded upon submission or receipt of such data or information.

SECTION 12. Contracts with vendors.

(a) Any contract with any vendor other than a sole source vendor for purchase of services or for purchase or lease of supplies and equipment related to the council's powers and duties shall be let only after a public bidding process and only in accordance with the following provisions, and no contract shall be let by the council that does not conform to these provisions:

a. The council shall prepare specifications fully describing the services to be rendered or equipment or supplies to be provided by a vendor and shall make these specifications available for inspection by any person at the council's offices during normal working hours and at such other places and such other times as the council deems advisable.

b. The council shall publish notice of invitations to bid. The council shall also publish such notice in at least four newspapers in general circulation in the Commonwealth on at least three occasions at intervals of not less than three days. Said notice shall include at least the following:

i. The deadline for submission of bids by prospective vendors, which shall be no sooner than 30 days following the latest publication of the notice as prescribed in this paragraph.

ii. The locations, dates and times during which prospective vendors can examine the specifications required in paragraph (a).

iii. The date, time and place of the meeting or meetings of the council at which bids will be opened and accepted.

iv. A statement to the effect that any person is eligible to bid.

c. Bids shall be accepted as follows:

i. No council member who is affiliated in any way with any bidder shall vote on the awarding of any contract for which said bidder has submitted a bid, and any council member who has an affiliation with a bidder shall state the nature of the affiliation prior to any vote of the council.

ii. Bids shall be opened and reviewed by the appropriate council committee, which shall make recommendations to the council on approval. Bids shall be accepted and such acceptance shall be announced only at a public meeting of the council as defined in section 2(e), and no bids shall be accepted at an executive session of the council.

iii. The council may require that a certified check, in an amount determined by the council, accompany every bid, and, when so required, no bid shall be accepted unless so accompanied.

d. In order to prevent any party from deliberately underbidding contracts in order to gain or prevent access to council data, the council may award any contract at its discretion, regardless of the amount of the bid, pursuant to the following:

i. Any bid accepted must reasonably reflect the actual cost of services provided.

ii. Any vendor so selected by the council shall be found by the council to be of such character and such integrity as to assure, to the maximum extent possible, adherence to all the provisions of this act in the provision of contracted services.

iii. The council may require the selected vendor to furnish, within 20 days after the contract has been awarded, a bond with suitable and reasonable requirements guaranteeing the services to be performed with sufficient surety in an amount determined by the council, and upon failure to furnish such bond within the time specified, the previous award shall be void.

iv. The council shall make efforts to assure that its vendors have established affirmative action plans to assure equal opportunity policies for hiring and promoting employees.

SECTION 13. Reporting.

The council shall provide an annual report of its financial expenditures to the House Ways and Means Committee and the Senate Ways and Means Committee of the Massachusetts Legislature.

SECTION 14. Health Care Finance Unit.

The Health Care Finance Unit is hereby established within the Health Care Cost Containment Council. The council shall oversee the unit and shall employee other staff necessary pursuant to section 3 to comply with the following provisions in this section. The executive director pursuant to section 3 shall oversee the duties and functions of the unit.

(a) General Duties and Functions of the unit.

a. To make an annual report to the council and the general court the first Wednesday in November specifying the management of its affairs, an analysis of reimbursement policy for each class of providers of services and for state institutions, a projection of the percentage change and fiscal impact of any changes in rates or regulations for every provider and program under its jurisdiction for the fiscal year beginning July first in the year following such November first, a detailed analysis of the factors influencing each increase and an explanation for any rate increase in excess of the consumer price index. Said report shall further detail efforts of the unit to coordinate its rate making function with rule making functions of other state agencies regulating said providers and institutions, and its recommendations for legislation, if any.

b. To provide, on a basis calculated to reduce or contain the costs of the program, a program of insurance coverage for health care services for persons in the commonwealth who are not otherwise eligible for or covered by a health insurance plan, a self-insurance health plan, a medical assistance program or any other plan or program which provides for payment by a third-party payer for health care services;

c. To design and to revise, consistent with this chapter, a basic schedule of health care services that enrollees in any health insurance program implemented by the unit shall be eligible to receive. Such covered services shall include those which typically are included in employer-sponsored health benefit plans in the commonwealth. The unit may promulgate schedules of covered health care services which differ from the basic schedule and which apply to specific classes of enrollees. The unit may promulgate a schedule of premium contributions, co-payments, co-insurance, and deductibles for said programs, including reduced premiums based on a sliding fee, and other fees and revise them from time to

time, subject to the approval of the division of insurance; and provided, however, that such schedule shall provide for such enrollees to pay one hundred per cent of such premium contributions if their income substantially exceeds the non-farm poverty guidelines of the United States office of management and budget;

d. To establish rates pursuant to this section to be paid providers of health care services by governmental units, including the division of industrial accidents which are reasonable and adequate to meet the costs which are incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable state and federal law, regulations and quality and safety standards, and which are within the financial capacity of the commonwealth. The unit shall have the responsibility for establishing fair and adequate charges to be used by state institutions for general health supplies, care or rehabilitative services and accommodations, which charges shall be based on the actual costs of each state institution reasonably related, in the circumstances of each institution, to the efficient production of such services in such institution and shall also have sole responsibility for determining rates paid for educational assessments conducted or performed by psychologists and other trained certified educational personnel pursuant to the tenth paragraph of section 3 of chapter 71B of the General Laws, notwithstanding the provisions of an other special or general law or rule or regulation to the contrary;

i. The unit (1) shall determine, after public hearing, at least annually for institutional providers, and at least biennially for non-institutional providers, the rates to be paid by each governmental unit to providers of health care services; (2) shall determine, after public hearing, at least annually, the rates to be charged by each state institution for general health supplies, care or rehabilitative services and accommodations; (3) shall certify to each affected governmental unit the rates so determined; (4) shall determine, after public hearing, at least annually, and certify to the division of industrial accidents of the department of labor and industries, rates of payment for general health supplies, care or rehabilitative services and accommodations, which rates shall be paid for services under chapter 152; (5) shall, upon request of the division of insurance, assist the division of insurance in the performance of its duties as set forth in section four of chapter one hundred and

seventy-six B; (6) may establish fair and reasonable classifications upon which any rates may be based for rest homes, nursing homes and convalescent homes; provided, however, that the unit shall not cause a decrease in a rate or add a penalty to a rate because such home has an equity position which is less than zero.

ii. The unit shall establish such rates for nursing homes and rest homes, as defined under section seventy-one of chapter one hundred and eleven, as of October first of each year for facilities whose rate is set on a retrospective basis and as of January first of each year for facilities whose rate is set on a prospective basis. In setting such prospective or retrospective rates of reimbursement, the unit shall use as base year costs for rate determination purposes the reported costs of the calendar year not more than four years prior to the current rate year, adjusted for reasonableness and to incorporate any audit findings applicable to said base year costs; provided, however, that no base year cost shall be incorporated unless a comprehensive desk audit has been completed for the costs incurred in that base year. In any appeal of any matter arising out of the setting of such prospective rates of reimbursement, the aggrieved party shall not be permitted to introduce into the record of such an appeal evidence of costs for any year other than the base year used to establish the rate. Notwithstanding any other general or special law or regulation to the contrary, except as provided in chapter one hundred and eighteen E, each governmental unit shall pay to a provider of services and each state institution shall charge as a provider of health care services, as the case may be, the rates for general health supplies, care and rehabilitative services and accommodations determined and certified by the unit.

iii. The unit, in establishing rates of payment to providers of services, shall control rate increases and shall impose such methods and standards as are necessary to ensure reimbursement for those costs which must be incurred by efficiently and economically operated facilities and providers. Such methods and standards may include, but are not limited to the following: peer group cost analyses; ceilings on capital and operating costs; productivity standards; caps or other limitations on the utilization of temporary nursing or other personnel services; use of national or regional indices to measure increases or decreases in reasonable costs;

limits on administrative costs associated with the use of management companies; the availability of discounts for large volume purchasers; the revision of existing historical cost bases, where applicable, to reflect norms or models of efficient service delivery; and other means to encourage the cost-efficient delivery of services. Rates produced using these methods and standards shall be in conformance with Title XIX, including the upper limit on provider payments.

iv. The unit, in determining rates to be paid by governmental units to providers of services, shall include as an operating expense of a provider of services any contribution made in lieu of taxes by such provider of services to a city or town and shall establish by regulation those expenses treated as business deductions under the Internal Revenue Code, which shall be included as allowable operating expenses in determining rates of reimbursement. Except for ceilings or maximum rates of reimbursement, which are determined in accordance with rate determination methods imposed on nursing homes, any ceiling or maximum imposed by the unit upon the rate of reimbursement to be paid to rest homes shall reflect the actual costs of rest home providers and shall not prevent any such rest home provider from receiving full payment for costs necessarily incurred in the provision of services in compliance with federal or state regulations and requirements.

v. The unit, in determining rates to be paid by governmental units to acute-care hospitals, as defined in section 25B of chapter 111, and any hospital or separate unit of a hospital that provides acute psychiatric services, as defined in said section 25B, shall include as an operating expense the reasonable cost of providing competent interpreter services as required by section 25J of said chapter 111 or section 23A of chapter 123. No hospital shall receive reimbursement or payment from any governmental unit for amounts paid to employees, as salary, or to consultant or other firms, as fees, where the primary responsibility of the employees or consultants is, either directly or indirectly, to persuade or seek to persuade the employees of the hospital to support or oppose unionization. Attorney's fees for services rendered in dealing directly with a union, in advising hospital management of its responsibilities under the National Labor Relations Act, or for services at an administrative agency or court or for services by an

attorney in preparation for the agency or in court proceeding shall not be deemed to be support or opposition to unionization.

vi. The unit shall establish rates on a prospective basis, subject to rules and regulations promulgated by the unit whenever possible; provided, however, that whenever the unit by regulation provides that a final rate for a reporting period shall be computed on the actual cost of a provider of services, or a state institution, for such period, it shall establish an interim rate for said provider or institution within twenty-one days of the beginning of said interim rate period, from which interim rate said provider may appeal as provided under section thirty-six.

vii. The unit shall also adopt regulations pursuant to council approval to enable each provider or institution to secure adjustment in said interim rate from time to time to meet current reasonable costs. Said provider or institution shall have the right at any time to petition the unit for an increase in said interim rate. A petition for an adjustment in an interim rate shall include a certified statement that such a petition is not interposed for delay, a detailed explanation, under oath, of the basis upon which said increase is sought, together with a sworn statement of an independent licensed accountant or independent certified public accountant that he has examined the pertinent data relative to the accounts forming the basis of the petition and that in his opinion, said accounts are as represented by the petitioner. The petitioner shall provide such other information as the unit shall require. The unit, subject to council approval, may create such rules and regulations that may waive the required independent audit for non-institutional providers whenever the unit determines that such audit would create a financial hardship. The executive director shall report in writing his recommendations to the petitioner, giving his reasons therefore in detail, and the petitioner shall have ten days to file objections, arguments and comments to the unit. The unit shall thereupon make a rate determination, which shall become effective when filed with the state secretary. No appeal under section nine of this chapter shall be allowed from an interim rate determined under the provisions of this paragraph.

viii. The unit shall, whenever a final rate for a filing period is to be determined after the end of such period, calculate a preliminary final rate within 60 days after receipt of a satisfactory financial

and operating cost report from a provider of services or state institution for such filing period. If such reports provide all the information required by the unit and are attested to by an independent licensed accountant or an independent certified public accountant in such a manner and form as the unit may require, the unit may, prior to a field audit, establish such preliminary final rate on the basis of such information submitted. No appeal may be taken from such preliminary final rate. Ninety percent of the difference between the interim rate and said preliminary final rate shall become payable by or to governmental units when certified to the state secretary. Said preliminary final rate may be promulgated as the final rate of a provider of services or state institution if the unit is satisfied with a provider's report. In the event that a final rate is determined without a field audit, the unit shall institute such procedures, including random field audits, as are required to assure accurate reporting by providers of health care services and state institutions. If the unit is not satisfied with the provider's report, the unit shall within six months and after a field audit promulgate a different rate of payment.

ix. The unit, in establishing rates for nursing pools pursuant to section seventy-two Y of chapter one hundred and eleven, shall take into consideration wages and benefits paid by the pool to the medical personnel supplied to a health care facility and that portion of the rate attributable to wages and benefits shall not exceed the prevailing wages and benefits allowed for permanent medical personnel of the same type at such health care facilities. Such rate shall also take into consideration the reasonable administrative expenses and an allowance, which shall provide a reasonable return on equity. The unit shall establish procedures whereby nursing pools shall submit accountable cost reports, which may be subject to audit, to the unit for the purpose of establishing such rates. The unit shall establish interim rates for nursing pools until such time as said reports are complete.

x. The unit shall set rates for rest homes, nursing homes and convalescent homes, beginning with interim rates for the rate year beginning October first, nineteen hundred and eighty-nine, by recalculating the base year whenever estimated costs for payments to nursing pools are no longer reflective of or are higher than actual costs to such facilities for such payments.

xi. Notwithstanding the provisions of any general or special law or any rule or regulation to the contrary, the unit, in determining the rate of payment for prescribed drugs dispensed to publicly-aided or industrial accident patients by pharmacy providers, shall not apply or use, either directly or indirectly, a discount from the primary standard used by the unit in establishing such rate.

xii. Except as otherwise provided in this section any person aggrieved by any rate determination made under this section shall have a right of appeal as provided under section nine.

xiii. The unit may enter into such contracts or agreements with the federal government, a political subdivision of the commonwealth, or any public or private corporation or organization, as it deems necessary; provided, however, that the unit shall not enter into any contract or agreement with a private corporation or organization to furnish information and statistical data to be used by said unit as its sole basis for setting rates, if such private corporation or organization is to make or receive payments based upon the rates so set.

xiv. Each governmental unit shall cooperate with the health finance unit at all times in the furtherance of the unit's purposes. Each state institution shall permit the unit or any designated representatives thereof, to examine its books and accounts and shall file with the unit from time to time or upon request such data, statistics, schedules or other information as the unit may reasonably require.

xv. Each rate established by the unit shall be deemed a regulation and shall be subject to review as hereinafter provided. The unit shall promulgate rules and regulations for the administration of its duties and the determination of rates as are herein required subject to the procedures prescribed by chapter thirty A. Every rate, classification and other regulation established by the unit shall be consistent where applicable with the principles of reimbursement for provider costs in effect from time to time under Titles XVIII and XIX of the Social Security Act governing reimbursements or grants available to the commonwealth, its departments, agencies, boards, divisions or political subdivisions for general health supplies, care, and rehabilitative services and accommodations.

xvi. In the event that any aggregate rates certified by the unit exceed the upper limit of payment in effect for any period under Titles XVIII or Title XIX of the Social Security Act or any other requirement of said Titles, where applicable, the unit shall redetermine and recertify any such aggregate rates in order to bring them into compliance with such federal requirement for the entire period during which such upper limit is effective. The provisions of this section shall not apply to acute or non-acute hospitals; provided, however, that the provisions of this section shall apply to acute and non-acute hospitals for services under the workers' compensation act. Upon petition of a receiver appointed under section seventy-two N of chapter one hundred and eleven, the unit shall, in accordance with regulations to be promulgated hereunder, adjust the facility's rate, if necessary, to insure compensation of the receiver and payment for a bond. Such adjustment shall not be in effect if the licensee is under the jurisdiction of the United States Bankruptcy Court.

xvii. All rates of payment to acute hospitals and non-acute hospitals under Title XIX shall be established by contract between the provider of such hospital services and the unit of medical assistance, except as provided in subsections (a) and (b), or otherwise permitted by law. All rates shall be subject to all applicable Title XIX statutory and regulatory requirements.

xviii. All such rates for non-acute hospitals shall be effective as of the date specified in section thirteen A of chapter one hundred and eighteen E of the General Laws, unless otherwise specified by law.

xix. For disproportionate share hospitals, the unit shall establish rates that equal the financial requirements of providing care to recipients of medical assistance.

xx. The unit shall establish rates of payment which shall apply to emergency services and continuing emergency care provided in acute hospitals to medical assistance program recipients, including examination or treatment for an emergency medical condition or active labor in women or any other care rendered to the extent required by 42 USC 1395(dd), unless such services are provided pursuant to an agreement between the division of medical assistance and the acute hospital. Such rates of payment shall reflect the reasonable costs of providing such care and shall take into

account the characteristics of the hospital in which such care is provided, including, but not limited to, its status as a teaching hospital, specialty hospital, disproportionate share hospital or sole community provider. An acute hospital shall, when a medical assistance program recipient requires post emergency room care and, after screening and stabilizing the patient's condition, notify the division of medical assistance or its designated representative and assist said division, to the extent possible, in transferring the recipient to an appropriate medical setting in accordance with said division's direction. Nothing herein shall be construed to require the hospital to breach its obligation under said 42 USC 1395(dd) or require the recipient to forego any right to refuse transfer pursuant to said 42 USC 1395(dd). If an acute hospital is unable or prohibited by law or regulation from transferring the patient in accordance with said division's direction, said division shall pay for any and all care associated with such patient's treatment including, but not limited to, care or services provided in the emergency room or in an inpatient or outpatient setting. Whenever said division is required to pay for such care rendered in a non-emergency room setting, said division shall pay all reasonable costs for such services in such hospital, as determined by the division of health care finance and policy pursuant to this chapter and consistent with the provisions of Title XIX laws.

xxi. All rates of payment to acute hospitals and non-acute hospitals under Title XIX shall be established by contract between the provider of such hospital services and the division of medical assistance, except as provided in subsections (a) and (b), or otherwise permitted by law. All rates shall be subject to all applicable Title XIX statutory and regulatory requirements and shall include reimbursement for the reasonable cost of providing competent interpreter services pursuant to section 25J of chapter 111 or section 23A of chapter 123.

xxii. All such rates for non-acute hospitals shall be effective as of the date specified in section thirteen A of chapter one hundred and eighteen E of the General Laws, unless otherwise specified by law.

xxiii. For disproportionate share hospitals, the unit shall establish rates that equal the financial requirements of providing care to recipients of medical assistance.

xxiv. The unit shall establish rates of payment which shall apply to emergency services and continuing emergency care provided in acute hospitals to medical assistance program recipients, including examination or treatment for an emergency medical condition or active labor in women or any other care rendered to the extent required by 42 USC 1395(dd), unless such services are provided pursuant to an agreement between the division of medical assistance and the acute hospital. Such rates of payment shall reflect the reasonable costs of providing such care, including the costs of providing competent interpreter services pursuant to section 25J of chapter 111 or section 23A of chapter 123 and shall take into account the characteristics of the hospital in which such care is provided, including, but not limited to, its status as a teaching hospital, specialty hospital, disproportionate share hospital or sole community provider. An acute hospital shall, when a medical assistance program recipient requires post emergency room care and, after screening and stabilizing the patient's condition, notify the division of medical assistance or its designated representative and assist said division, to the extent possible, in transferring the recipient to an appropriate medical setting in accordance with said division's direction. Nothing herein shall be construed to require the hospital to breach its obligation under said 42 USC 1395(dd) or require the recipient to forego any right to refuse transfer pursuant to said 42 USC 1395(dd). If an acute hospital is unable or prohibited by law or regulation from transferring the patient in accordance with said division's direction, said division shall pay for any and all care associated with such patient's treatment including, but not limited to, care or services provided in the emergency room or in an inpatient or outpatient setting. Whenever said division is required to pay for such care rendered in a non-emergency room setting, said division shall pay all reasonable costs for such services in such hospital, as determined by the unit pursuant to this chapter and consistent with the provisions of Title XIX laws.

xxv. No acute hospital may charge to a governmental unit for services provided to publicly aided patients at a rate higher than the rate payable by the division of medical assistance under Title XIX for the same service, unless such service is provided by said

division pursuant to a unique arrangement such as a selective contract or a managed care contract.

xxvi. Nothing in this chapter shall be construed to conflict with the provisions of a waiver of otherwise applicable federal requirements which the division of medical assistance may obtain from the secretary of health and human services for the purpose of implementing a primary care case management system for delivering services, or for the purpose of implementing any other type of managed care service delivery system in which the eligible recipient is directed to obtain services exclusively from one provider or one group of providers.

xxvii. If the division of medical assistance contracts with any third party payer for the provision of medical benefits for medical assistance recipients under Title XIX, said division shall assure that on a quarterly basis such contracted third party payers notify each acute hospital of the number of inpatient days of service provided by the hospital to such recipients covered by such contracts.

xxviii. The unit shall establish rates of payment which shall apply to community hospitals located in rural and isolated areas where access to other such providers is not reasonably available. Such hospitals, specially designated by the commonwealth as sole community providers, shall receive payment rates calculated to reflect the rural characteristics of such community hospital and the essential nature of the services they provide, which rates shall not be less than ninety-seven per cent of such hospitals' reasonable financial requirements.

xxix. The unit shall not consider the following as resources of such hospitals in the establishment, review or approval of acute and non-acute hospital rates and charges: restricted and unrestricted grants; gifts; contributions; bequests; fund principle; term endowments and endowment balances; restricted gifts; unrestricted gifts and all income from any of the foregoing, including unrestricted income from endowment funds and income and gains from investment of unrestricted funds. The following words shall have the following meanings as used in this paragraph:

1. "Income and gains from investment of unrestricted funds", interest, dividends, rents or other income on investments, including net gains or losses resulting from investment transactions.

2. "Term endowment", funds available upon termination of restrictions.

3. "Unrestricted gifts", gifts, grants, contributions and bequests, upon which there are no restrictions imposed by the donor.

4. "Unrestricted income from endowment funds", income earned on investment of endowment funds which have no restrictions on income.

5. An acute or non-acute care hospital aggrieved by any action or failure to act by the unit under this chapter may file an appeal pursuant to the provision of section nine.

xxx. Except for rates established pursuant to section eleven, any person, corporation or other party aggrieved by an interim rate or a final rate established by the unit, or by failure of the unit to set a rate or to take other action required by law and desiring a review thereof shall, within thirty days after said rate is filed with the state secretary or may, at any time, if there is a failure to determine a rate or take any action required by law, file an appeal with the division of hearings officers established by section four H of chapter seven. Any appeal filed under this section shall be accompanied by a certified statement that said appeal is not interposed for delay. On appeal, the rate determined for any provider of services shall be adequate, fair and reasonable for such provider, based upon, the costs of such provider, but not limited thereto.

xxxi. On an appeal from an interim rate or a final rate the division of hearings officers shall conduct an adjudicatory proceeding in accordance with chapter thirty A, and said division shall file its decision with the unit and the state secretary within thirty days after the conclusion of the hearing.

xxxii. Said decision shall contain a statement of the reasons therefore, including a determination of each issue of fact or law upon which such decision was based. If such decision results in a recommendation for a rate different from that certified, the unit shall establish a new rate based upon such statement of reasons. If the executive director determines that the statement of reasons is inadequate to determine a fair, reasonable and adequate rate, it may remand the appeal to the hearing officer for further investigation. Any party aggrieved by a decision of the unit may, within thirty days of the receipt of such decision, file a petition for

review in superior court for the county of Suffolk, which shall have exclusive jurisdiction thereof.

xxxiii. A provider may appeal as an aggrieved party in accordance with the provisions of the preceding sentence, in the event that a remand by the unit to a hearing officer does not result in a final decision within twenty-one days of the date of remand. The petition shall set forth the grounds upon which the decision of the unit should be set aside. The aggrieved party shall, within seven days after the petition for review is filed, notify the unit and all the parties to the appeal that a petition for review has been filed by sending each a copy thereof. Within forty days after the petition for review is filed, or within such further time as the court may allow, the division of hearings officers shall file in court the original or a certified copy of the record under review. The court may affirm, modify or set aside the decision of the unit in whole or in part, remand the decision to the unit for further proceedings, or enter such other order as justice may require. Nothing herein shall be construed to prevent the division of hearing from granting temporary relief if, in its discretion, such relief is justified nor, from informally adjusting or settling controversies with the consent of all parties. Judicial review shall be governed by section fourteen of chapter thirty A to the extent not inconsistent with the provisions of this section.

SECTION 15. Payment of Expenses by Acute Hospitals.

Each acute hospital shall pay to the commonwealth an amount for the estimated expenses of the unit. Such amount shall be equal to the amount appropriated by the general court for the expenses of the unit minus amounts collected from (1) filing fees, (2) fees and charges generated by the unit's publication or dissemination of reports and information, and (3) federal matching revenues received for such expenses or received retroactively for expenses of predecessor agencies. Each acute hospital shall pay such net amount multiplied by the ratio of the hospital's gross patient service revenues to the total of all such hospital's gross patient services revenues. Each acute hospital shall make a preliminary payment to the unit on October first of each year in an amount equal to one-half of the previous year's total assessment. Thereafter, each hospital shall pay, within thirty days notice from the

unit, the balance of the total assessment for the current year based upon its most current projected gross patient service revenue. The unit shall subsequently adjust the assessment for any variation in actual and estimated expenses of the unit and for changes in hospital gross patient service revenue. Such estimated and actual expenses shall include an amount equal to the cost of fringe benefits, as established by the division of administration pursuant to section six B of chapter twenty-nine. In the event of late payment by any such hospital, the treasurer shall advance the amount of due and unpaid funds to the unit prior to the receipt of such monies in anticipation of such revenues up to the amount authorized in the then current budget attributable to such assessments, and the unit shall reimburse the treasurer for such advances upon receipt of such revenues. The provisions of this paragraph shall not apply to any state institution or to any acute hospital which is operated by a city or town.

SECTION 16. Conditions for reimbursement.

Any provider of health care services that receives reimbursement or payment for treatment of injured workers under chapter one hundred fifty-two and any provider of health care services other than an acute or non-acute hospital that receives reimbursement or payment from any governmental unit for general health supplies, care and rehabilitative services and accommodations, shall, as a condition of such reimbursement or payment: (1) permit the unit, or any designated representative thereof, the attorney general or his designee, to examine such books and accounts as may reasonably be required for it to perform its duties; (2) file with the unit from time to time or on request, such data, statistics, schedules, or other information as it may reasonably require, including outcome data and such information regarding the costs, if any, of such provider for research in the basic biomedical or health delivery areas or for the training of health care personnel which are included in its charges to the public for health care services, supplies and accommodations; and (3) accept reimbursement or payment at the rates established by the unit, subject to a right of appeal under section nine, as discharging in full any and all obligations of an eligible person and the governmental unit to pay, reimburse or compensate the provider of health care services in any

way for general health supplies, care, and rehabilitative services or accommodations provided.

SECTION 17. All purchasers and third party payers, excluding purchasers and payers under the workers' compensation act, except as provided in chapter one hundred fifty-two, may enter into contractual arrangements with acute and non-acute hospitals for services. No such arrangement, including but not limited to prices or charges which may be charged for non-contracted services or which may be negotiated in individual contracts between such purchasers or third party payers and such acute or non-acute hospitals, shall be subject to prior approval by any public agency; provided, however, that nothing in this section or chapter shall limit the authority of the unit to establish rates of payment for all health care services adjudged compensable under chapter one hundred fifty-two, and provided, further, that charges established by an acute or non-acute hospital for health care services rendered shall be uniform for all patients receiving comparable services.

Any acute or non-acute hospital that makes a charge or accepts payment based upon a charge in excess of that filed required or approved by the unit or that fails to file any data, statistics or schedules or other information required under this chapter or by any regulation promulgated by the council or which falsifies the same, shall be subject to a civil penalty of not more than one thousand dollars for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the commonwealth in any court of competent jurisdiction. The attorney general shall bring any appropriate action, including injunctive relief, as may be necessary for the enforcement of the provisions of this chapter.

SECTION 18. Access to care and services for chapter 117A recipients.

No acute hospital shall deny access to care and services which the hospital would provide under chapter one hundred and eighteen E to recipients of benefits under chapter one hundred and seventeen A.

SECTION 19. Surcharges for residents of other countries.

Notwithstanding any provisions of this chapter to the contrary, all costs and charges for patients who are residents of other countries shall, as provided herein, be exempted from the limitations imposed by this chapter. Any hospital shall be allowed to impose a surcharge on the normal charges that would otherwise be allowed for such residents of other countries. Such surcharges shall not be included in the calculation of gross patient service revenues. The normal charge and the patient discharge statistics shall otherwise be included under the provisions of this chapter.

SECTION 20. Contract rights of HMOs.

A health maintenance organization organized under chapter one hundred and seventy-six G may (i) negotiate directly with any hospital with respect to such health maintenance organization's rate of payment for hospital services and (ii) enter into an agreement with such hospital reflecting such rate of payment without the approval of the council established under chapter one hundred eighteen G. The specification in this section of contracting rights of health maintenance organizations shall not be construed as affirming or denying such rights with respect to any other third party payer.

SECTION 21. Small business health insurance programs.

(a) The unit may establish programs to enable small businesses to purchase health insurance for their employees at rates which are as equivalent as possible to the rates at which large employers can purchase health insurance. Such programs shall include, but not be limited to, the following:

a. the study of the insurance market and the practices of insurance companies, hospital service corporations, medical service corporations and health maintenance organizations, to determine the causes of the relative unavailability of health insurance plans for small businesses and of disproportionate health insurance premium costs for small businesses and to recommend and develop initiatives and strategies to improve the availability and reduce the relative cost of health insurance for small businesses;

b. the awarding of technical assistance grants to private organizations to assist them to act as brokers on behalf of small businesses seeking to procure health insurance plans;

c. the establishment of a small business health insurance pool for businesses consisting of six or fewer full-time employees, for the purpose of purchasing health insurance plans for employees and their dependents of businesses in the pool, and the study of the expansion of such pool to cover small businesses of up to ten full-time employees; provided, however, that not more than thirty per cent in the aggregate of the employees may be enrolled in a health insurance plan of a single health insurance company, hospital service corporation, or health maintenance organization;

d. the evaluation of the effectiveness of the initiatives of the unit and tax incentives in reducing the cost of health insurance to small businesses and the impact of such voluntary incentives on the number of small businesses offering health insurance to their employees.

(b) Any small business health insurance pool program established by the unit may, subject to appropriation or the availability of unappropriated funds, establish by negotiation with private third-party payors, and purchase on such terms as it deems to be in the best interest of the commonwealth and enrollees in said program, from one or more insurance companies, hospital service corporations, medical service corporations, or health maintenance organizations, a policy of group general or blanket insurance providing hospital, surgical, medical, and other health insurance benefits covering persons who are the employees and their dependents of small businesses in which the number of full-time employees does not exceed six. The council shall oversee all the unit's agreements and the unit shall execute all agreements or contracts pertaining to said policies or any amendments thereto for and on behalf of and in the name of the unit, pursuant to section 12 and upon final approval of the council. Said unit may negotiate a contract for such term not to exceed three years as it may, in its discretion, deem to be the most advantageous to the unit and the eligible small business employees. The unit shall endeavor to purchase health insurance plans in an economical manner and shall enroll individuals in managed health care plans whenever practicable; and provided, further, that the unit shall ensure that every enrollee shall have a choice of at least two policies providing health care insurance benefits. The unit shall promulgate regulations regarding eligibility criteria, enrollment, and termination

policies. The unit shall allow, on an annual basis, an opportunity for enrollees to transfer their enrollments among participating health insurance plans. The unit shall establish a schedule of premium contributions, co-payments, deductibles, or co-insurance amounts to be paid by eligible small businesses and individual enrollees; provided, however that such schedule shall provide for enrollees to pay one hundred per cent of such premium contributions if their income substantially exceeds the non-farm poverty guidelines of the United States Office of Management and Budget.

SECTION 22. Uncompensated Care Pool.

(a) The third party administrator shall, without imposing undue hardship upon any individual, to secure payment for unpaid bills owed to acute hospitals by persons ineligible for free care 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 Uncompensated Care Trust Fund; and provided, further, that all actions to secure such payments shall be conducted in compliance with a protocol previously submitted by the former division of health care finance and policy to the committee on health care and the house and senate committees on ways and means.

(b) There is hereby established an Uncompensated Care Trust Fund, which shall be administered by the third party administrator. Expenditures from said Trust Fund shall not be subject to appropriation unless otherwise required by law. The purpose of said fund shall be to provide access to health care for low income uninsured and underinsured residents of the commonwealth. The third party administrator shall administer said fund using such methods, policies, procedures, standards and criteria that the unit has approved as necessary for the proper and efficient operation of said fund and the programs funded thereby in a manner consistent with simplicity of administration, the provisions of this chapter and the best interests of low income uninsured and underinsured persons.

(b) The Uncompensated Care Trust Fund shall consist of all amounts paid by acute hospitals and surcharge payors for the pur-

poses of the uncompensated care pool pursuant to this act; all appropriations for the purpose of uncompensated acute hospital care or uncompensated community health center care; any sums paid by acute hospitals pursuant to section 56 of chapter 495 of the acts of 1991; all property and securities acquired by and through the use of monies belonging to said fund and all interest thereon; less payments therefrom for the purposes of the uncompensated care pool and amounts transferred to the separate MassHealth account established by subsection (c). All interest earned on the amounts in said fund shall be deposited or retained in said fund. The unit shall from time to time requisition from said fund such amounts as it deems necessary in order for the third party administrator to meet its current obligations for the purposes of said fund and estimated obligations for a reasonable future period.

(c) Within said fund, the unit shall establish a separate account for the insurance reimbursement program component of the MassHealth demonstration program established by section 9C of chapter 118E. This separate account shall consist of amounts transferred from the Uncompensated Care Trust Fund, any federal funds transferred from the Children's and Seniors' Health Care Assistance Fund established by section 2FF of chapter 29, and any funds as may be appropriated for deposit into this account. The unit shall administer this account and disburse funds from this account for the purposes of said insurance reimbursement program component of said MassHealth program. Funds deposited in this account shall be kept separate and shall not be commingled with funds of the uncompensated care pool. The comptroller is hereby authorized and directed to effect the transfers authorized by this subsection pursuant to a spending plan filed by the division of medical assistance with the secretary of administration and finance and the house and senate committees on ways and means.

(d) Within said fund, the third party administrator shall administer an uncompensated care pool consisting of revenues produced by acute hospital assessments and the surcharge percentage calculated by the third party administrator pursuant to this section and section 18A and all appropriations for the purpose of uncompensated care provided by acute hospitals, or community health centers, including, but not limited to, federal funds made available for

uncompensated care payments to certain acute hospitals as may be appropriated from the General Fund or any other fund. For purposes of this subsection, the words "revenues produced by acute hospital assessments" shall equal the value of and have the same meaning as the words "acute hospitals' liability to the pool" established pursuant to subsection (e) and the words "revenues produced by the surcharge percentage" shall equal the value of and have the same meaning as the words "surcharge payors' liability to the pool" as established pursuant to section 18A. Amounts placed in the Uncompensated Care Trust Fund, except for amounts transferred into the separate MassHealth account established in subsection (c), shall be expended by the third party administrator for the purposes of the uncompensated care pool. The third party administrator shall administer the uncompensated care pool and require payments to the pool and disburse funds from the pool consistent with the surcharge payors' and acute hospitals' liability to the pool and the pool's liability to an acute hospital or a community health center. The unit shall specify by regulation, appropriate mechanisms that provide for interim determination and payment of a surcharge payor's liability to the pool and an acute hospital's liability to and from the pool during each fiscal year and for final settlement of the pool for each fiscal year. The unit may promulgate regulations, which authorize the assessment of interest on any unpaid liability at a rate not to exceed an annual percentage rate of 18 per cent and late fees at a rate not to exceed 5 per cent per month. The unit may calculate final settlements when it determines that data for a fiscal year are substantially complete and that further refinements would not materially affect the calculation. The unit may incorporate final settlement amounts by prospective adjustment of acute hospitals' and surcharge payors' liability rather than by retrospective payments or assessments.

(e) An acute hospital's liability to said pool shall equal the product of (1) the ratio of its private sector charges to all acute hospitals' private sector charges; and (2) the private sector liability to the uncompensated care pool as determined by law less the surcharge payors' liability established pursuant to section 18A. Before October 1 of each year, the unit shall establish each acute hospital's liability to the pool using the best data available,

as determined by the unit. The unit shall update each acute hospital's liability to the pool as updated information becomes available. For any fiscal year, an acute hospital's final liability to said pool shall be calculated in accordance with subsection (d). The unit shall specify by regulation an appropriate mechanism for interim determination and payment of an acute hospital's liability to and from said pool.

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

(g) The unit shall establish by regulation an appropriate mechanism for enforcing an acute hospital's liability to the pool in the event that an acute hospital does not make a scheduled payment to said pool. Such enforcement mechanism may include notification to the division of medical assistance requiring an offset of payments on the Title XIX claims of any such acute hospital, any health care provider under common ownership with the acute hospital or any successor in interest to the acute hospital, from the division of medical assistance in the amount of payment owed to said pool including any interest and late fees, and to transfer the withheld funds into said pool. If the division of medical assistance offsets claims payments as ordered by the division, it shall be deemed not to be in breach of contract or any other obligation for payment of noncontracted services, and providers to which payment is offset under order of the division shall serve all Title XIX recipients in accordance with the contract then in effect with the division of medical assistance, 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 this chapter. In no event shall the division direct the division of medical assistance to offset claims unless an acute hospital has maintained an outstanding obligation to the uncompensated care pool for a period longer than 45 days and has received proper notice that said division intends to initiate enforcement actions in accordance with the regulations of said division.

(h) Said pool's liability to an acute hospital shall be calculated periodically by the unit based on the best data available. Such data shall include, but not be limited to, allowable free care charges as determined by the division and the cost-to-charge ratio, which

shall be calculated by the unit for each acute hospital. The final settlement of the pool's liability to a hospital shall equal the product of allowable actual free care charges, adjusted for any audit findings, multiplied by its final cost-to-charge ratio. In the case of non-disproportionate share hospitals, such calculation shall represent the ratio of the reasonable actual costs of patient care services, as determined by the unit, to gross patient service revenue for the most recent year for which audited financial statements for the hospital are available. In the case of disproportionate share hospitals, such calculation shall represent the ratio of the hospital's reasonable financial requirements, as determined by the unit, to gross patient service revenue for the most recent year for which audited financial statements for such hospital are available. The unit shall, throughout the year, update each acute hospital's ratio in the event more current audited financial statement information becomes available. Said unit shall further establish, for each non-disproportionate share acute hospital for any given fiscal year, a final ratio using the reasonable costs for patient care services and gross patient service revenues as appearing in the audited financial statements for the fiscal year. For disproportionate share hospitals, said unit shall establish a final ratio based upon its reasonable financial requirements, as defined by the unit, and actual gross patient service revenues as appearing in the audited financial statements for the fiscal year. The final settlement of the pool's liability to an acute hospital shall be calculated in accordance with subsection (d). The pool's liability to a community health center shall be calculated periodically by the unit based on the best data available as determined by the division. Such data shall include, but not be limited to, allowable free care charges as determined by the unit and the rates established by the unit to be paid for free care services. Such rates shall represent the community health center's reasonable financial requirements, as determined by the unit.

(i) The unit shall manage said pool in order to encourage maximum efficiency and appropriateness in the utilization of services. The unit shall promulgate regulations detailing the definition of free care, including, but not limited to, defining the qualifications of eligible persons and the scope of eligible services, setting standards for reasonable efforts to notify uninsured or underinsured

persons of the various insurance options as well as the availability of free care, and setting standards for reasonable efforts to collect costs of emergency care and setting standards to determine medical hardship. Said regulations shall include provision for the review of determinations of eligibility for free care and the establishment of penalties for acute hospitals or community health centers which upon audit show an excessive rate of incorrect eligibility determinations. The unit shall adopt regulations prohibiting payments from said pool for non-urgent and non-emergency health care services provided to residents of other states and foreign countries. The unit may require utilization review. After consultation with consumer representatives and representatives of acute hospitals and community health centers, the unit shall develop programs and guidelines to encourage maximum enrollment of pool beneficiaries into health care plans and programs of health insurance offered by public and private sources, and to promote the delivery of care in the most appropriate setting, through coordination of care and referral of primary care cases to community health centers. Such programs and guidelines shall not deny payments on the ground that services should have been provided in a more appropriate setting if the hospital was required to provide such services pursuant to 42 USC 1395(dd). The unit may adopt regulations requiring disproportionate share hospitals to use a portion of payments received from said pool to reimburse physicians for the costs of free care which such physicians provide in such hospitals. In adopting regulations under this subsection, the unit shall consult and work cooperatively with representatives of low income uninsured and underinsured persons, health care providers who provide health care to such persons, and organizations representing said persons and providers.

(j) The unit shall adopt any other regulations necessary for the third party administrator to manage said pool including, but not limited to, regulations: requiring data submissions, setting pool audit standards, establishing enforcement mechanisms consistent with this section, and establishing reasonable controls on utilization. The unit shall require acute hospitals and community health centers to submit data to the administrator that the unit determines necessary to efficiently and effectively administer the uncompensated care pool. Said data may include, but shall not be limited to,

charge and cost data, patient diagnoses and types of uncompensated service provided, patient demographics, write-off amounts, unique patient identifiers and other such data that would enable the unit to conduct analyses, verify eligibility and calculate settlements on a case-by-case basis. The unit shall consider all available options for collecting said data, including claims and electronic data submission, and shall implement the most efficient and effective method after consultation with interested parties. If the unit finds that hospitals are not complying with the data submission requirements or if the data submitted are not sufficient to enable the unit to verify eligibility and calculate settlements on a case-by-case basis, the unit may adopt regulations providing for a claims adjudication process for payments from the uncompensated care pool. Such claims adjudication process shall maximize administrative simplicity to the extent practicable and shall not significantly delay cash flow from said pool. The unit shall consult with interested parties, including the Massachusetts hospital association, in developing the methodology for such claims adjudication process and shall submit the methodology to the joint committee on health care 90 days in advance of adopting such regulations. The third party administrator shall analyze the data collected under this section in conjunction with any other pertinent data to determine the demographic characteristics and the clinical and social needs of uncompensated care recipients. If said analysis indicates that one or more managed care or case management programs would better meet the needs of low income individuals, the division shall consult with representatives of the uninsured and underinsured and the providers who serve them and other interested parties regarding the potential for managed care or case management approaches to improve care provided under said pool. If the unit determines that such approaches would improve care, the unit may contract pursuant to council approval and section 12 with health care delivery or management organizations or to enter interagency service agreements with the division of medical assistance or the department of public health for the purpose of contracts with health care or managed care providers to deliver services to individuals eligible for free care or; provided, however, that no such contract shall be entered into until the unit finds that the cost of such contract does not exceed the amounts

that would otherwise have been expended on free care for these individuals; and, provided further, that the expenditures for such contracts shall not exceed $5,000,000 in any hospital fiscal year.

(k) The unit shall promulgate regulations to develop and implement methods and procedures to verify the eligibility of individuals for free care and to ensure that other coverage options are utilized fully before free care is granted. These systems may include but are not limited to investigation and recovery of third party liabilities, and penalties for noncompliance. The unit shall compile and maintain a catalog of program information for all programs of health care coverage for low income persons including those sponsored by public and private organizations. The catalog shall include, at a minimum, eligibility criteria, benefits and services offered, enrollment procedures and information necessary for contact and follow-up. The unit shall ensure that if free care is granted for the copayment and deductible of an eligible person with other coverage, no payments shall be made from the uncompensated care pool which would cause the total payment to the provider to exceed the applicable rates for free care services. The unit 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 including, but not limited to, the Medicaid or Medicare program, or if the individual is not eligible for free care. The unit shall require acute hospitals and community health centers to screen each free care applicant for other sources of coverage and for potential eligibility for government programs, and to document the results of such screening. If an acute hospital or community health center determines that an applicant is potentially eligible for Medicaid or another government program, said acute hospital or community health center shall assist the applicant in applying for benefits under such program. The third party administrator shall audit free care accounts of acute hospitals and community health centers to determine compliance with this section and shall deny pool payment for any audited account for any acute hospital or community health center that fails to document compliance with this section.

(l) The unit may enter into interagency agreements with the department of revenue to verify income data for recipients of free

care. Such written agreements shall include provisions permitting the unit to provide a list of persons receiving or applying for free care, including any applicable members of the households of such recipients or applicants which would be counted in determining eligibility, and to furnish relevant information including, but not limited to, name, social security number, if available, and other data required to assure positive identification. Such written agreements shall include provisions permitting the department of revenue to examine the data available under the wage reporting system established under section 3 of chapter 62E and make positive identification of cases in which recipients or applicants for free care, individually or as part of a household unit, are receiving wages in excess of any threshold eligibility requirements established by the division. The department of revenue is hereby authorized to furnish the unit with information on the cases of persons so identified, including, but not limited to, name, social security number and other data to ensure positive identification, name and identification number of employer, and amount of wages received. The unit may inform acute hospitals and community health centers only of an individuals eligibility or noneligibility for free care based on information obtained from the department of revenue, but may not release any specific information concerning the individual.

(m) The third party administrator shall deposit any amounts received pursuant to chapter 62D in the Uncompensated Care Trust Fund to reimburse the uncompensated care pool for expenditures made for persons who received free care through said pool and who, upon review, was determined to be ineligible for uncompensated care based upon applicable income standards.

(n) The third party administrator shall not at any time make payments from said pool for any period in excess of amounts that have been paid into or are available in said pool for such period; provided, however, that the unit may temporarily prorate payments from said pool for cash flow purposes. In the event that after making allowable free care payments to community health centers, there exists a shortfall of pool revenue, excluding any revenue in the separate MassHealth insurance reimbursement program account, in any fiscal year to cover allowable free care payments to acute hospitals, the administrator shall allocate such payments so that those acute hospitals with the greatest propor-

tional requirement for pool income shall receive a greater proportional payment from said pool. In the event that there exists a surplus of pool revenue in any fiscal year over that necessary to cover allowable free care payments, the administrator shall apply such surplus to allowable free care payments for any succeeding fiscal year in which there is a shortfall of pool revenue.

(o) Within the Uncompensated Care Trust Fund, there shall be established a medical assistance intergovernmental transfer account, administered by the commissioner of the division of medical assistance, consisting of any transfers to the commonwealth from publicly-operated entities providing Title XIX or Title XXI reimbursable services, and federal reimbursements related to medical assistance payments, so called, to publicly-operated entities. All amounts credited to this account shall be held in trust and shall be available for expenditure by the commissioner of the division of medical assistance to be used for medical assistance payments to entities designated and authorized by the general court, or which have contractually agreed to make intergovernmental transfers to said account; provided, however, that any amount in excess of such medical assistance payments may be credited to the General Fund; provided, further, that the amount of all such expenditures shall be subject to annual approval by the general court. The maximum payments and transfers from said account shall not exceed those permissible for federal reimbursement under Title XIX or Title XXI of the Social Security Act or any successor federal statute. The comptroller may make payments, including payments during the accounts payable period, in anticipation of revenues, including receivables due and collectibles during the months of July and August, and shall establish procedures for reconciling overpayments or underpayments from said account to publicly-operated entities; provided, that said procedures shall include, but not be limited to, appropriate mechanisms for refunding intergovernmental transfers and federal reimbursements upon recoupment of any such overpayments. The division of medical assistance shall notify the unit regarding revenue and expenditure activity within said account and submit to the secretary of administration and finance and the house and senate committees on ways and means a schedule of said payments ten days prior to any expenditures, and no funds shall be

expended without an enforceable agreement with or legal obligation imposed upon the recipient public entity to make an intergovernmental transfer in an appropriate amount to said account.

SECTION 23. Health care for the medically indigent.

(a) Declaration of policy.—The General Court finds that every person in this Commonwealth should receive timely and appropriate health care services from any provider operating in this Commonwealth; that, as a continuing condition of licensure, each provider should offer and provide medically necessary, lifesaving and emergency health care services to every person in this Commonwealth, regardless of financial status or ability to pay; and that health care facilities may transfer patients only in instances where the facility lacks the staff or facilities to properly render definitive treatment.

(b) Studies on indigent care.—To reduce the undue burden on the several providers that disproportionately treat medically indigent people on an uncompensated basis, to contain the long-term costs generated by untreated or delayed treatment of illness and disease and to determine the most appropriate means of treating and financing the treatment of medically indigent persons, the council, at the request of the Governor or the General Court, may undertake studies and utilize its current data base to:

a. Study and analyze the medically indigent population, the magnitude of uncompensated care for the medically indigent, the degree of access to and the result of any lack of access by the medically indigent to appropriate care, the types of providers and the settings in which they provide indigent care and the cost of the provision of that care pursuant to subsection (c).

b. Determine, from studies undertaken under paragraph (b), a definition of the medically indigent population and the most appropriate method for the delivery of timely and appropriate health care services to the medically indigent.

(c) Studies.—The council shall conduct studies pursuant to subsection (b)(1) and thereafter report to the General Court the results of the studies and its recommendations. The council may contract with an independent vendor to conduct studies in accordance with the provisions for selecting vendors in section 12. The studies shall include, but not be limited to, the following:

a. the number and characteristics of the medically indigent population, including such factors as income, employment status, health status, patterns of health care utilization, type of health care needed and utilized, eligibility for health care insurance, distribution of this population on a geographic basis and by age, sex and racial or linguistic characteristics, and the changes in these characteristics, including the following:

i. the needs and problems of indigent persons in urban areas;

ii. the needs and problems of indigent persons in rural areas;

iii. the needs and problems of indigent persons who are members of racial or linguistic minorities;

iv. the needs and problems of indigent persons in areas of high unemployment; and

v. the needs and problems of the underinsured;

b. the degree of and any change in access of this population to sources of health care, including hospitals, physicians and other providers; the distribution and means of financing indigent care between and among providers, insurers, government, purchasers and consumers, and the effect of that distribution on each;

c. the major types of care rendered to the indigent, the setting in which each type of care is rendered and the need for additional care of each type by the indigent;

d. the likely impact of changes in the health delivery system, including managed care entities, and the effects of cost containment in the Commonwealth on the access to, availability of and financing of needed care for the indigent, including the impact on providers which provide a disproportionate amount of care to the indigent;

e. the distribution of delivered care and actual cost to render such care by provider, region and subregion;

f. the provision of care to the indigent through improvements in the primary health care system, including the management of needed hospital care by primary care providers;

g. innovative means to finance and deliver care to the medically indigent; and

h. reduction in the dependence of indigent persons on hospital services through improvements in preventive health measures.

SECTION 24. Effective date.

This act shall take effect immediately.