An Act Establishing Massachusetts Medicare for All

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An Act Establishing Massachusetts Medicare for All

SECTION 1. The General Laws are amended by inserting the following chapter after Chapter 175M: Chapter 175N MASSACHUSETTS MEDICARE FOR ALL.

Section 1. Definitions

(a) The following words and phrases shall have these meanings except where the context requires otherwise:
  (1) Accreditation Association for Ambulatory Healthcare: A non-profit organization that accredits ambulatory healthcare facilities.
  (2) AMA: American Medical Association.
  (3) Beneficiary: A resident entitled to free healthcare under Massachusetts Medicare for All, as specified in Section 9 (Beneficiaries).
  (4) Benefit: A covered benefit, as specified in Section 13 (Benefits).
  (5) Biometric identification: A method for identifying individuals based on one or more unique physical characteristics.
  (6) Board: The Massachusetts Medicare for All Board of Trustees, as specified in Section 5 (Board of Trustees).

(7) CMS: The U.S. Centers for Medicare and Medicaid Services.
(8) Collateral source: A source of funding for the Medicare for All trust that is not provided by taxes on Massachusetts residents and businesses, as specified in Section 4(g) (Funding Sources).
(9) Committee: The Economic Advisory Committee when appearing in Section 7 (Economic Advisory Committee) or the Benefits Advisory Committee when appearing in Section 14 (Benefits Advisory Committee).
(10) CPAP: Continuous positive airway pressure administered by a device to manage sleep apnea.
(11) CPT: The Current Procedural Terminology coding system developed and maintained by the American Medical Association.
(12) Department: The Massachusetts Department of Revenue.
(13) Division of Insurance: The Division of Insurance of the Massachusetts Executive Branch.
(14) Durable equipment and nondurable supplies: Medically necessary equipment and supplies prescribed by a provider for a beneficiary:
  (i) Durable medical equipment are items like wheelchairs, crutches, nebulizers, CPAP machines, oxygen equipment, and prosthetic devices
  (ii) Nondurable supplies are items like disposable gloves, antiseptic solutions, bandages, cotton swabs, and catheters.
(15) Economic Advisory Committee: The committee appointed by the Executive Director, as specified in Section 7 (Economic Advisory Committee).
(16) Embryo: The product of conception during pregnancy from fertilization to the end of the eighth week of pregnancy.
(17) Employee: An employee who pays Massachusetts taxes.
(18) Employer: An employer that pays Massachusetts taxes.
(19) Executive Director: The Massachusetts Medicare for All chief executive officer, as specified in Section 6 (Executive Director).
(20) FDA: The U.S. Food and Drug Administration.
(21) Fee-for-service: A method for paying providers for delivering benefits to beneficiaries, in contrast with global fees.
(22) Fetus: The product of conception from the end of the eighth week of pregnancy to birth.
(23) Fiscal year of the trust: The same as the state's fiscal year.
(24) Formulary: A document listing the prescription drugs paid for by a healthcare insurer and their costs (co-pays) to insured individuals.
(25) Fund: An entity's accumulation of money used to finance its projects and support its operations.
(26) General Fund: Massachusetts' primary fund.
(27) General Laws: The laws governing Massachusetts.
(28) Governor: The Governor of Massachusetts.
(29) HCPCS Level I: The Healthcare Common Procedure Coding System, which is the part of the CPT coding system that providers use to submit claims for services to beneficiaries, as specified in Section 11(d) (Provider Payment).
(30) HCPCS Level II: The coding system that providers use to submit claims for durable and nondurable goods and services not included in the HCPCS Level I CPT codes, as specified in Section 11(e) (Provider Payment).

(31) Health and Human Services: The Massachusetts Executive Office of Health and Human Services.
(32) Healthcare: The healthcare provided to beneficiaries by providers.
(33) Healthcare facility: An organization developed, maintained, and operated for the diagnosis, treatment, or prevention of illness, physical or mental, or injury, as specified in Section 10 (Providers).
(34) Healthcare professional: An individual, medical group, independent practice association, or other entity licensed or authorized by law to provide the benefits specified in Section 13 (Benefits).
(35) Healthcare Professionals Advisory Committee (HCPAC): The part of the AMA's CPT Advisory Committee comprised of non-physician allied health professionals and limited-license practitioners who advise the CPT Editorial Panel on CPT coding and nomenclature.
(36) HIPAA: The Health Insurance Portability and Accountability Act issued by the U.S. Department of Health and Human Services.
(37) Home care: Healthcare provided in the beneficiary's home.
(38) Hospital Readmissions Reduction Program (HRRP): A system developed by the Centers for Medicare and Medicaid Services to capture unplanned readmissions to a hospital within 30 days of a patient's discharge from inpatient care. Patients readmitted to the same or another acute-care hospital are included.
(39) ICD-10-CM: The International Classification of Diseases, Tenth Revision, Clinical Modification – a coding system of medical diagnoses developed and maintained by the U.S. National Center for Health Statistics (NCHS).
(40) Inpatient care: Healthcare provided in a healthcare facility, as defined in this section, where the beneficiary stays for at least 24 hours.
(41) Instrumentality: An instrument or means to an end.
(42) Joint Commission: A nonprofit organization that accredits inpatient and ambulatory healthcare facilities; the leading American accreditor of inpatient healthcare facilities.
(43) Legislature: The Massachusetts Senate and House of Representatives.
(44) Medically necessary: Benefits necessary to meet national standards of care established by scientific evidence and generally accepted by the medical community.
(45) Outpatient care: Healthcare provided to a beneficiary in a healthcare professional's office or a healthcare facility lasting less than 24 hours, in contrast with inpatient care, as defined in this section.
(46) Prescription drugs: Medically necessary drugs prescribed by healthcare professionals legally authorized to write prescriptions.
(47) Provider: A healthcare professional or facility, as specified in Section 10 (Providers).
(48) QR code: A machine-readable (Quick Reference) code consisting of a matrix of black squares.
(49) Resident: A person who lives in Massachusetts as evidenced by an intent to continue living in Massachusetts and returning to Massachusetts if temporarily absent, coupled with an act or acts consistent with that intent. The trust shall adopt standards and procedures for determining whether a person is a resident, including provisions requiring that:
   (i) The person seeking resident status has the burden of proof in such determination;
   (ii) A residence established only to obtain free healthcare shall not be evidence that a person is a Massachusetts resident;

(iii) Homeless, incarcerated, and undocumented individuals shall be considered residents.

(50) Secretary: The secretary of the Massachusetts Executive Office of Health and Human Services.

(51) Second opinion: A second healthcare professional's opinion regarding another provider's diagnosis or recommendation.

(52) State: Massachusetts.

(53) Subcutaneous: Under the skin.

(54) Subrogation: An insurance company's right to request reimbursement from another party for money paid to cover a claim.

(55) Taxpayer: An individual or company that pays Massachusetts taxes.

(56) Trust: A legal entity with distinct rights, similar to a person or corporation but managed by a board of trustees. Because Massachusetts Medicare for All is established as a trust, "trust" is used interchangeably with "Massachusetts Medicare for All."

(57) Trust fund: The accumulation of money used to finance the trust's projects and expenditures.

(58) Trustees: Members of the Board of Trustees.

(59) Virtual: An encounter between or among individuals that does not involve direct contact but, instead, uses an electronic method to communicate, including but not limited to video conferencing, telephone calls, and text messages in which there is immediate and continuous give and take between two parties. Email messages are not virtual encounters.

Section 2. Massachusetts Medicare for All

(a) Massachusetts declares that healthcare is a human right.

(b) Massachusetts shall provide free healthcare insurance to all its residents, as defined in Section 1 (Definitions). To do this, the state shall become an insurer compliant with relevant sections of the Division of Insurance regulations: Code of Massachusetts Regulations CMR 211.

(c) The healthcare insurance program defined in this section shall be known as Massachusetts Medicare for All and established as a trust within the Executive Office of Health and Human Services but not under its control.

(d) The trust shall be administered by an Executive Director appointed by the Secretary, with the Governor's approval, after a nationwide search, as specified in Section 6 (Executive Director).

(e) Massachusetts Medicare for All shall be based on Medicare Part C (also known as Medicare Advantage), as described in U.S. Title XVIII of the Social Security Act.

(f) Massachusetts Medicare for All shall expand the benefits of Medicare Part C to cover all the healthcare needs of Massachusetts residents as specified in Section 13 (Benefits).

(g) All Massachusetts residents shall automatically be enrolled in Massachusetts Medicare for All when it is fully implemented, except that beneficiaries of federal healthcare programs, as specified in (h) of this section, shall not be enrolled.

(h) Beneficiaries of federal healthcare programs other than Medicare shall continue to receive the healthcare benefits of their respective programs, which include but are not limited to:
 (1) Medicaid;
 (2) The Children's Health Insurance Program (CHIP);
 (3) The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA);
 (4) The Department of Defense healthcare program for active-duty service members, active-duty family members, National Guard and Reserve members and their family members, retirees, and retiree family members, survivors, and certain former spouses (TRICARE);
 (5) TRICARE for Life (TFL);
 (6) The Indian Health Service (IHS) healthcare program.

(i) The trust shall collect and disburse funds required to provide free benefits, as specified in Section 13 (Benefits), to every resident, as defined in Section 1 (Definitions).

(j) The trust shall guarantee free and comprehensive healthcare to all beneficiaries, regardless of financial or employment status, ethnicity, race, religion, gender, gender identity, sexual orientation, geographic location, or previous health conditions.

(k) All financial transactions related to providers' payment for benefits delivered to beneficiaries shall be between the healthcare providers and the trust, as specified in Section 11 (Provider Payment). Beneficiaries shall not be financially responsible for any benefit specified in Section 13 (Benefits).

(l) Beneficiaries shall not be responsible for co-payments or any other form of cost-sharing.

(m) The trust shall constitute a Massachusetts public instrumentality, and the exercise of the trust's powers, as specified in this section, shall be deemed an essential governmental function.

(n) The trust shall have the powers to:
 (1) Make, amend, and repeal bylaws, rules, and regulations for the management of its affairs;
 (2) Adopt an official seal;
 (3) Sue and be sued in its own name;
 (4) Make contracts and execute all instruments necessary or convenient to effect the purposes of this bill;
 (5) Acquire, own, hold, dispose of, and encumber personal or intellectual property;
 (6) Enter into agreements or transactions with federal, state, or municipal agencies or other public or private institutions or private individuals, partnerships, firms, corporations, associations, or other entities;
 (7) Appear on its own behalf before boards, commissions, departments, or other agencies of federal, state, or municipal government;

(8) Appoint officers, hire employees, and engage independent contractors, including legal counsel, consultants, agents, and advisors, and prescribe their duties and fix their compensation;
(9) Establish and maintain advisory committees;
(10) Procure insurance against any losses in connection with its property in such amounts and from such insurers as may be necessary or desirable;
(11) Invest sinking or other funds held in reserve and not required for immediate disbursement, as may be lawful for fiduciaries in Massachusetts under Sections 38 and 38A of Chapter 29 of the Massachusetts General Laws relating to the investment of funds by state-owned trusts;
(12) Accept, hold, use, apply, and dispose of all donations, grants, and bequests of money, property, services, or other things of value that may be received from the United States or any governmental agency, institution, person, firm, or corporation, public or private.
(i) Such donations, grants, and bequests shall be held, used, applied, or disposed of for the purposes specified in this chapter and under the terms and conditions of such grants.
(ii) The receipt of donations, grants, and bequests shall be reported in the trust's annual report, including the identity of the donors or lenders, the nature of the transaction, and any conditions attached to the donation or grant.

(o) All communications from the trust shall comply with the privacy rule of the U.S. Health Insurance Portability and Accountability Act (HIPAA).

(p) Massachusetts Medicare for All will:
(1) Relieve all employers from paying for any healthcare benefits for current employees or retirees living in the state;
(2) Relieve all residents from paying any out-of-pocket costs for healthcare.
(3) Save money by replacing private healthcare insurance plans with an efficient, uniform, and comprehensive single-payer healthcare insurance program managed by the state;
(4) Reduce costs for municipalities, counties, the state, and businesses;
(5) Achieve measurable improvement in healthcare outcomes;
(6) Prevent disease and disability and maintain or improve the health and functionality of beneficiaries;
(7) Increase the satisfaction of healthcare professionals, beneficiaries, and employers with the healthcare system.

(q) Massachusetts Medicare for All shall be fully implemented 12 months after this bill is enacted.

Section 3. Trust Fund

(a) The Secretary shall establish a fund to support the trust within one month after this bill is enacted.

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(b) The trust fund shall be financed by the revenue sources specified in Section 4 (Funding Sources) and income from the trust's property, securities, and other assets.

(c) All claims from providers for benefits delivered to beneficiaries shall be made to the trust fund, and payments to providers shall be disbursed from the fund, as specified in Section 11 (Provider Payment).

(d) Amounts credited to the trust fund shall be used to:
- (1) Pay providers for benefits delivered to beneficiaries, as specified in Section 13 (Benefits);
- (2) Pay providers for preventive care, education, outreach, and public health risk reduction, not to exceed 5 percent of the trust's income in any fiscal year;
- (3) Help workers displaced by converting to a single-payer healthcare insurance system by:
  - (i) Paying for training programs;
  - (ii) Paying employment agencies;
  - (iii) Providing financial assistance to move their home to a location closer to their new employment.
  - (iv) The money allocated for these purposes shall be subject to guidelines established by the Executive Director.
  - (v) The assistance specified in this provision shall be available for two years after this bill is fully implemented, and eligible workers must apply before then to receive the assistance specified in this section.
  - (vi) The payments to displaced workers shall not exceed 2% of the trust's income in any fiscal year.
- (4) Fund a reserve account to finance anticipated long-term cost increases due to demographic changes, inflation, budgetary shortfalls, epidemics, and other extraordinary events that would increase the trust fund's liabilities, not to exceed 1 percent of the trust's income in any fiscal year. The reserve account shall not constitute more than 5 percent of the trust's assets.
- (5) Pay the administrative costs of the trust, which, within two years after this bill is enacted, shall not exceed 5 percent of the trust's income in any fiscal year.

(e) Unexpended trust assets shall not be deemed a "surplus" as defined by Chapter 29 Section 1 of the General Laws.

Section 4. Funding Sources

(a) The trust fund shall be the repository for all the trust's funds.

(b) Dedicated revenue streams that fund the trust shall not affect other Massachusetts public health programs.

(c) A fairly apportioned tax on employers, employees, and the self-employed shall replace the insurance premiums and out-of-pocket costs beneficiaries and employers previously paid for healthcare.
- (1) An employer payroll tax of 7.5 percent shall be assessed on employees' W-2 wages, exempting the first $20,000 of payroll per employer, replacing previous employers' costs for healthcare insurance premiums. An additional employer payroll tax of 0.5 percent shall be assessed on establishments with 100 or more employees;
- (2) An employee payroll tax of 2.5 percent shall be assessed, exempting the first $20,000 of income, replacing employees' previous costs for healthcare insurance premiums and

out-of-pocket expenses. All W-2 wages shall be combined for each taxpayer, and one $20,000 exemption shall be allowed;

(3) A 10 percent payroll tax on self-employed residents shall be assessed, including general partnership income and other federally taxable self-employment income. The income from all sources shall be combined, and each self-employed taxpayer shall be allowed one $20,000 exemption;

(4) For (2) and (3) above, each taxpayer shall combine all income reported on Massachusetts Form 1 and Schedule C and shall be allowed one $20,000 exemption. The exemption shall apply first to W-2 income and then to self-employment income;

(5) A 10 percent tax on unearned income and all other income not expressly excluded shall be assessed on income above $20,000.

(6) Capital gains from the portion of rental property attributed to a primary residence exceeding the exclusion allowed by Massachusetts law shall be subject to the tax on unearned income.

(7) Not taxed are Supplemental Security Income (SSI), Social Security Disability Income (SSDI), distributions from Roth Independent Retirement Accounts (IRAs), workers' compensation benefits, and payments made by employers who pay all or part of an employee's payroll tax obligation.

(d) Any entity that provides healthcare benefits under a contract with an employer or group of employers that is in effect when Massachusetts Medicare for All is implemented shall pay the trust fund an amount equal to the trust's payroll tax based on the number of each employer's employees.

(e) Until the role of all other payers for healthcare in Massachusetts has ended, healthcare costs shall be collected from collateral sources whenever benefits are provided that are covered by a collateral source, as defined in (g) of this section, to the extent permitted by law.

(f) Collateral sources shall be identified as specified in Section 4(r) (Funding Sources).

(g) Collateral sources include the entities paying for the following but not limited to them:

(1) Healthcare insurance that is part of pension plans or workers' compensation being paid on behalf of beneficiaries by out-of-state employers;

(2) Employer-sponsored healthcare insurance and health reimbursement arrangements (HRAs) paid for beneficiaries by out-of-state employers, which are relieved by the trust;

(3) Healthcare benefits included in automobile, homeowners, and other types of insurance;

(4) Judgments for damages for personal injury that are covered by the trust.

(5) Any other third party that is or may be liable for benefits to a beneficiary.

(h) Collateral sources do not include:

(1) Contracts or plans that are subject to federal preemption;

(2) Governmental units, agencies, or services to the extent that a law prohibits subrogation.

(i) Default, underpayment, or late payment of any tax or other obligation owed to the trust shall result in the trust imposing remedies and penalties provided by the law except as provided in this section.

(j) The Department of Revenue shall adopt the system the information technology division developed in collaboration with the department to collect the taxes specified in (c) and the revenues specified in (g) of this section. The department shall integrate this process into its system for collecting other taxes.

(k) Before the start of each Massachusetts fiscal year, the Executive Director, in consultation with the Secretary, shall prepare a revised budget for the upcoming fiscal year, with recommendations from the Economic Advisory Committee and the trustees, to deal with rising or declining revenues or expenditures, as specified in Section 12 (Budget).

(l) Eligibility for benefits shall not be impaired by any default, underpayment, or late payment of any tax or other obligation imposed by the trust.

(m) The legislature shall be empowered to transfer funds from the general fund sufficient to meet the trust's projected expenses beyond projected income from dedicated revenues, as specified in this section.
  (1) This transfer shall replace current general fund spending on healthcare benefits for state employees and patients at public inpatient facilities and other healthcare benefit programs financed by the state.

(n) The trust shall receive all monies paid to Massachusetts by the federal government for healthcare services covered by the trust.

(o) The trust shall seek to maximize all federal financial support for Massachusetts Medicare for All.
  (1) The Executive Director shall seek all necessary waivers, exemptions, agreements, or legislation to ensure that all federal payments for the healthcare of Massachusetts residents, consistent with federal law, are paid directly to the trust fund.
  (2) Federal financial support for the healthcare of residents who are beneficiaries of the federal programs specified in Section 2(h) (Massachusetts Medicare for All) and do not receive benefits from the trust fund is excluded from this requirement that all federal funds must be paid directly to the trust.

(p) In obtaining the waivers, exemptions, agreements, or legislation, the Executive Director shall seek from the federal government a contribution for healthcare services in Massachusetts that will not decrease compared with the contribution to other states as a result of the waivers, exemptions, agreements, or legislation.

(q) Whenever a beneficiary receives benefits, the provider shall determine whether the beneficiary is entitled to coverage, indemnity, or other compensation from a collateral source, as defined (g) of this section.
  (i) If so, the provider shall identify the source from the beneficiary and provide that information to the trust via the electronic form used to bill for the benefits delivered by the provider.
  (ii) The beneficiary shall provide the information needed for the trust to request reimbursement from the collateral source of the money the trust paid the provider for the benefits delivered at that encounter.

(iii) It shall be unlawful for a beneficiary to fail to disclose a collateral source or grant permission to the trust to seek reimbursement from a collateral source. Such failure shall disqualify them from receiving further benefits from the trust.

(r) The trust shall seek reimbursement from the collateral source for the money the trust paid to a provider for the benefits delivered to the beneficiary. The trust shall use lawful means, including legal actions, to recover the trust's costs for providing the benefits.

(s) The trust shall retain:
(1) All charitable donations, gifts, grants, or bequests made to it, from whatever source, consistent with state and federal law;
(2) Reimbursement from third-party payers for covered services delivered by providers to non-eligible patients but paid for by the trust;
(3) Income from the investment of the trust's assets, consistent with state and federal law.

(t) Massachusetts employers that have a contract with an insurer, health services corporation, or health maintenance organization to provide healthcare benefits for its employees that are in effect when this bill is enacted shall be entitled to an income tax credit for premiums subsequently paid up to one year after this bill is enacted.

Section 5. Board of Trustees

(a) An 11-member Board of Trustees shall govern the trust.
(1) Four of them shall be ex officio trustees who will be the sole trustees until the governor appoints the individuals specified in (a)(2) of this section:
(i) The Executive Director;
(ii) Secretary of Health and Human Services;
(iii) Secretary of Administration and Finance;
(iv) Commissioner of Public Health.
(2) The governor shall, within six months after this bill is enacted, appoint seven trustees nominated by the:
(i) Massachusetts Medical Association;
(ii) Massachusetts Nurses Association;
(iii) Massachusetts Health and Hospital Association;
(iv) Massachusetts Disability Law Center;
(v) Massachusetts Association for Mental Health;
(vi) National Business Group on Health (NBGH);
(vii) Executive Director, based on a statewide search for an economist with special knowledge of Massachusetts' healthcare economy, who is not a member of the Economic Advisory Committee.

(b) Appointed trustees shall serve five-year terms except that initially, three appointed trustees shall serve three-year terms, three shall serve four-year terms, and one shall serve a five-year term. The initially appointed trustees shall be assigned to a three-, four-, or five-year term by lot.

(c) Appointed trustees shall be eligible for reappointment for no more than two terms.

(d) Any person appointed to fill a vacancy on the board shall serve the unexpired term of their predecessor and be eligible for reappointment for two terms.

(e) The Governor may relieve any appointed trustee for cause and replace them with an individual nominated by the same organization that nominated their predecessor.

(f) The trustees shall elect a chair from among its members every two years. The chair shall be eligible for re-election to a maximum of two terms.

(g) A majority of the trustees shall constitute a quorum, and the affirmative vote of a majority of the trustees present shall be necessary for any action taken by the board.

(h) The trustees shall meet in person at least four times yearly for a regular meeting.
  (1) The chair shall prepare the agendas for all regular meetings.
  (2) The trustees shall be paid $1,000 per day for each in-person meeting attended and reimbursed for actual and necessary expenses for each full day, provided the costs are not payable by another taxpayer-supported public agency or agencies. For this section, a full day of meeting attendance shall mean presence at and participation in at least 75 percent of the total meeting time during any 24 hours.
  (3) A staff member shall prepare minutes of the trustees' meetings and distribute copies to each trustee within one week after the meeting. The committee shall review and approve or correct the minutes at its next meeting.

(i) The Secretary or Executive Director may call for a special virtual meeting of the trustees to discuss and advise on an urgent matter.
  (1) The Executive Director shall prepare the agendas for special meetings.
  (2) The trustees shall be paid $500 and no expenses for virtual meetings.
  (3) A staff member shall prepare minutes of special meetings and distribute copies to each trustee within one week after the meeting. The committee shall review and approve or correct the minutes remotely within two weeks after the virtual meeting.

(j) All the trustee's meetings shall comply with the Massachusetts Open Meeting Law, G.L. c. 30A, §§18-25.

(k) No trustee shall attempt to use their official position to influence a governmental decision in which they know or have reason to know that they or a family member, business partner, or colleague has any financial interest. The Governor shall remove any trustee after investigating and finding substantial evidence that this stipulation has been violated.

(l) The duties of the trustees shall include but not be limited to:
  (1) Approving the trust's annual budget, as specified in Section 12 (Budget).
  (2) Recommending:
    (i) Revisions to the trust's annual budget, as prepared by the Executive Director in consultation with the Secretary and the Economic Advisory Committee;
    (ii) Agenda items for the Economic Advisory Committee meetings;
    (iii) Additions or enhancements to the work products of the information technology division;

(iv) Any other modifications to the structure or function of the Massachusetts Medicare for All Trust the trustees think warranted.

(3) Advising the Secretary on the successors to the initial Executive Director, whom the Secretary will appoint with the approval of the Governor before the Board of Trustees becomes operational.

Section 6. Executive Director

(a) The Secretary shall appoint a search committee within one week after this bill is enacted to conduct a nationwide search for an Executive Director to be the trust's executive head.

(b) The Secretary, with the search committee's recommendation and the Governor's approval, shall appoint an Executive Director to be the trust's executive within two months after this bill is enacted.

(c) The Executive Director shall have:
  (1) At least a master's degree in a discipline closely related to the duties specified in section (d) below, including but not limited to:
    (i) Public health;
    (ii) Health sciences;
    (iii) Health policy;
    (iv) Health administration;
    (v) Healthcare quality;
    (vi) Healthcare regulation.
  (2) The negotiating and organizational skills needed to be the trust's chief executive officer;
  (3) The leadership skills needed to lead a complex organization by consensus.

(d) The Executive Director's duties shall include but not be limited to:
  (1) Hiring sufficient staff to administer Massachusetts Medicare for All;
  (2) Organizing the staff to manage the trust cost-effectively and with high quality;
  (3) Using the purchasing power of the state to negotiate price discounts for prescription drugs and durable and nondurable medical equipment and supplies;
  (4) Negotiating or establishing terms and conditions for the provision of high-quality healthcare benefits for the beneficiaries;
  (5) Ensuring that the information systems division develops the electronic systems specified in Section 8(e) (Information Management) for the efficient and cost-effective functioning of Massachusetts Medicare for All;
  (6) Overseeing the preparation of an initial and annual revision of the trust's budget;
  (7) Overseeing the preparation of annual benefits reviews to determine the adequacy of Massachusetts Medicare for All's benefits;
  (8) Preparing an annual report to be submitted to the Governor, the Secretary, the Senate President, and the House of Representatives Speaker. The annual report shall be made accessible to all Massachusetts residents.

(e) The Executive Director will utilize and coordinate with the offices, staff, and resources of the executive branch agencies, including but not limited to the

Executive Office of Health and Human Services, the Center for Health Information and Analysis, the Department of Revenue, the Division of Insurance, and the Industrial Accidents Board.

(f) All actions of the Executive Director shall be subject to the approval of the Secretary.

Section 7. Economic Advisory Committee

(a) The Executive Director shall begin a statewide search for members of the Economic Advisory Committee within one month of assuming office and, within two months, appoint the three most promising candidates willing to serve.

(b) The committee members' terms shall be three years.
  (1) Members shall be eligible for reappointment for two terms after their initial term.
  (2) One member shall initially be appointed to a one-year term, a second to a two-year term, and the third to a three-year term.
  (3) The various terms shall be assigned by lot.

(c) If a member resigns, completes their final term, or is replaced by the Executive Director with or without cause, the Executive Director shall replace them using the same method used to appoint them.
  (1) When replacing members at the end of their terms, the Executive Director shall begin the statewide search no later than two months before the term's expiration.

(d) The Executive Director shall be a non-voting committee member.

(e) The committee's meetings shall be scheduled to ensure a quorum of all three members.

(f) The committee's decisions will usually be made by consensus, but without a consensus, a majority vote shall determine the committee's actions or recommendations.

(g) The committee, at its initial meeting, shall:
  (1) Elect a chair by majority vote, who shall serve until the end of their term, when they shall be replaced, as specified in (c);
  (2) Prepare an initial budget to guide the equitable allocation of taxes paid by employees and employers to support the trust, as specified in Section (4)(c) (Funding Sources), using their best estimates of the anticipated revenues and expenses of the trust.
    (i) The Executive Director, in consultation with the Secretary, shall adopt the budget the committee prepares if they approve it.

(h) The committee shall meet in person annually soon after the end of the trust's fiscal year:
  (1) To review and recommend revisions to the budget based on the trust's previous fiscal year's revenues and expenses.
    (i) The Executive Director and the Secretary shall adopt the revised allocation of taxes and their amounts if they and the trustees approve the revision.
  (2) To review the allocation of taxes and their amounts, as specified in Section 4(c) (Funding Sources), and make recommendations to the Executive Director for changes, giving the reasons for the committee's recommendations.
    (i) The Executive Director, in consultation with the Secretary shall, at their discretion, revise the allocation of taxes and their amounts according to the Economic Advisory Committee's recommendations.
  (3) To consider any other matter brought to its attention by the Executive Director or the Secretary.

(j) The Executive Director shall prepare the committee meeting agendas in consultation with the chair.
- The committee chair shall preside over the meetings.
- A staff member shall prepare minutes of the meetings and distribute copies to each committee member within one week after the meeting. The committee shall review and approve or correct the minutes remotely within three weeks after each meeting.

(k) The Executive Director may call special committee meetings to address topics that require immediate attention. Special meetings may be virtual, in which case the Executive Director shall chair the meeting, members shall be paid $500 for participation, and no expenses shall be paid.

(l) All the committee's meetings shall comply with the Massachusetts Open Meeting Law, G.L. c. 30A, §§18-25.

Section 8. Information Management

(a) The Executive Director, with the approval of the Secretary, shall appoint a Chief of Information Technology within two months after taking office.

(b) Essential qualifications of the Chief of Information Technology shall include
  (1) Competence in the development of computer networks that enable the secure transfer of data and communication between the trust and beneficiaries and providers;
  (2) Knowledge sufficient to create and maintain electronic relational databases;
  (3) Knowledge of the strengths and weaknesses of electronic medical records systems commonly used by healthcare professionals and facilities
  (4) The leadership qualities required to lead a team of information technology specialists in developing and maintaining the information systems needed to manage the trust safely and effectively.

(c) The Chief of Information Technology shall build an information technology division of trust within two months of their appointment.

(d) The information technology division, within eight months after its formation, shall, under the leadership of the Chief of Information Technology, develop:
  (1) A relational accounting database related to and integrated into the database the Department of Revenue uses for taxing individuals and businesses;
  (2) An account for each beneficiary containing all the records necessary to receive the benefits of Massachusetts Medicare for All.
    (i) The information technology division shall develop the beneficiaries' accounts in collaboration with the department.
    (ii) The beneficiaries' accounts shall be related to and integrated into the taxpayer accounts maintained by the department.

(e) The information technology division, within eight months after its formation, shall, under the leadership of the Chief of Information Technology, develop electronic methods for:
  (1) Beneficiaries to identify themselves electronically without a physical identification card. Such electronic methods may include:
    (i) A QR code on the beneficiary's digital device;
    (ii) A dependable method to identify beneficiaries using biometric identification, as defined in Section 1 (Definitions);
    (iii) A chip permanently affixed to the beneficiary (e.g., subcutaneously);
    (iv) Any other safe and dependable method for identifying the beneficiary electronically;
    (v) If a beneficiary does not have an appropriate electronic method for identification available (e.g., a cell phone), the Executive Director shall arrange for them to receive a conventional plastic ID card.
  (2) The department to collect the taxes specified in Section 4 (Funding Sources);
  (3) The department to pay providers, as specified in Section 11 (Provider Payment), as an integral part of the department's existing method for collecting taxes from individuals and businesses;
  (4) The department to electronically receive claims for benefits and disburse payment to providers, as specified in Section 11 (Provider Payment). Providers shall not use paper forms to submit claims;
  (5) The department to pay providers for benefits delivered by direct deposit to their bank account through the Automated Clearing House (ACH) network. No checks shall be issued to providers;
    (i) The department to reimburse federal beneficiaries for deductibles, co-payments, co-insurance, or other cost-sharing expenses associated with their federal coverage. The department may issue checks to federal beneficiaries.

Section 9. Beneficiaries

(a) The following individuals shall be beneficiaries of the trust:
   (1) Residents, as defined in Section 1 (Definitions);
   (2) Beneficiaries of federal programs, to the extent that they shall be Massachusetts Medicare for All beneficiaries only as specified in Section 2(f) (Massachusetts Medicare for All);
   (3) Non-residents who:
      (i) Work an average of at least 20 hours per week in Massachusetts and pay all applicable Massachusetts personal income, payroll taxes, and any additional premiums the trust establishes to cover non-residents.
      (ii) Require emergency treatment for illness or injury in California.
         - The trust shall recoup expenses for such benefits whenever possible.

   (4) A resident's embryo or fetus requiring healthcare independent of the beneficiary's personal healthcare needs.

(b) The Executive Director shall negotiate reasonable payment for emergency healthcare of beneficiaries obtained out of state.

(c) Visitors to California shall be billed for the benefits received from the trust for the money it paid, according to the trust's fee schedule.

(d) The Executive Director may establish intergovernmental arrangements with other states and countries to provide reciprocal visitor coverage.

Section 10. Providers

(a) Providers shall include healthcare professionals, healthcare facilities, organizations, agencies, corporations, or other entities that render direct healthcare benefits to beneficiaries, provided they:
   (1) Are licensed or otherwise authorized to practice or operate in Massachusetts;
   (2) Provide only medically necessary healthcare, as defined in Section 1 (Definitions);
   (3) Do not accept payment from other sources for services paid for by the trust;
   (4) Furnish a signed agreement stating that they will:
      (i) Provide benefits without discrimination based on factors including but not limited to age, sex, race, national origin, sexual orientation, gender identity, income status, preexisting condition, or citizenship status;
      (ii) Comply with all state and federal laws regarding the confidentiality of patient records and information, including those required by HIPAA, as defined in Section 1 (Definitions);
      (iii) Not bill beneficiaries for any out-of-pocket costs;
      (iv) Furnish the information the trust requires to make payment, verify payment information, perform utilization review and statistical and fiscal studies, and ensure compliance with state and federal laws;

(v) Meet state and federal quality guidelines for safe staffing, quality of care, and efficient use of funds for direct patient care.

(b) Duties of providers shall include but are not limited to providing beneficiaries with:
  (1) Medically necessary benefits.
    (i) If a beneficiary requests a non-medically necessary benefit, the provider shall explain why it is not medically necessary.
    (ii) If a provider's moral, ethical, or religious convictions make them reluctant to deliver a medically necessary benefit, they shall explain their concerns to the beneficiary and refer them to a provider who will deliver the benefit.
      - If the benefit requires emergency attention, the provider shall balance the beneficiary's welfare with the strength of their convictions, choosing the beneficiary's welfare if any doubt.
  (2) Access to copies of their medical records, including paper or digital copies, at no charge.
    (1) The provider should require the beneficiary to provide written HIPAA consent if they request that a copy of their medical records be sent to someone other than themselves.

Section 11. Provider Payment

(a) The Department of Revenue, within 12 months after this bill is enacted, shall adopt the electronic methods developed by the information technology division (in collaboration with the department) to:
  (1) Pay providers electronically for delivering benefits to beneficiaries using the method developed by the information technology division integrated into the department's existing process for collecting taxes from individuals and businesses;
  (2) Electronically receive claims for benefits and disburse payment to providers
    (i) Providers shall not use paper forms to submit claims;
    (ii) The department shall pay providers by direct deposit to their bank accounts through the Automated Clearing House (ACH) network.
      - The department shall not issue checks to providers.

(b) Healthcare professionals shall be paid fee-for-service based on the American Medical Association's CPT (Current Procedural Terminology) coding system and the Physician Fee Schedule (PSF) that is updated annually by the Centers for Medicare and Medicaid Services (CMS).
  (1) The AMA's Relative Value Scale Update Committee (RUC) develops a resource-based relative value scale (RBRVS) that assigns a relative value unit (RVU) to every CPT code.
  (2) The RUC determines an RVU for every CPT code by adding together three components: provider work RVU (wRVU), practice expense RVU (peRVU), and malpractice risk RVU (mpRVU), which the RUC assigns based on its collective judgment.
  (3) The rate for each CPT code is calculated by multiplying the RVU by a conversion factor updated annually by the Centers for Medicare & Medicaid Services (CMS).

CMS publishes an updated Physician Fee Schedule (PFS) with a value for every CPT code annually.

(c) Healthcare professionals shall submit CPT codes, also referred to as Healthcare Common Procedure Coding System (HCPCS) Level I codes, to request payment for benefits most benefits, as specified in Section 13 (Benefits).

(d) Providers shall submit HCPCS Level II codes, which the Centers for Medicare and Medicaid Services (CMS) updates annually, to request payment for benefits not covered by Level I CPT codes, such as durable equipment and nondurable supplies.

(e) Healthcare facilities shall be paid for inpatient services according to the Inpatient Prospective Payment System (IPPS), which is based on the operating costs of hospital inpatient healthcare services.
   (1) The Centers for Medicare and Medicaid Services (CMS) assigns a diagnosis-related group (DRG) to every inpatient service based on diagnosis, procedures performed, complicating conditions, age, sex, and discharge status.
   (2) These considerations determine the average cost of resources for treating patients with a given DRG.
   (3) The trust shall pay the healthcare facility for its benefits to beneficiaries according to the DRGs assigned to those benefits.

(f) Healthcare facilities shall submit ICD-10-CM (International Classification of Diseases, 10th Revision, Clinical Modification) codes maintained by the ICD-10 Coordination and Maintenance Committee, which is made up of representatives of the CDC's National Center for Health Statistics (NCHS), to bill the trust for benefits not covered by DRGs, such as hospital outpatient services.

(g) Hospitals shall not discharge beneficiaries from inpatient care to constrain the cost of providing them with the benefits covered by a given ICD-10-CM code before their discharge is medically indicated.
   (1) The Executive Secretary shall monitor readmission rates using the Hospital Readmissions Reduction Program (HRRP), an electronic monitoring system that identifies hospitals with readmission rates significantly higher than those with comparable patient demographic profiles.
   (2) The Executive Secretary shall impose sanctions on hospitals with readmission rates significantly higher than those with comparable patient demographic profiles.
      (i) Sanctions shall include but not be limited to a fine up to five times the payment the trust paid the hospital for the inpatient care that was not medically necessary.

Section 12. Budget

(a) The Executive Director, with the approval of the Secretary and input from the Economic Advisory Committee, shall:
  (1) Establish an initial budget for the trust within 12 months after this bill is enacted;
  (2) Review and revise the budget, as indicated, with input from the Economic Advisory Committee and approval of the trustees, based on discrepancies between the trust's budgeted and actual revenues and expenditures during the fiscal year just ending.

(b) The purpose of the budget is to help manage the trust's assets by estimating its:
  (1) Revenues, including but not limited to receipts from the sources specified in Section 4 (Funding Sources);
  (2) Expenses, including but not limited to paying:
    (i) Providers for the benefits delivered to beneficiaries, as specified in Section 11 (Provider Payment);
    (ii) The salaries of the Executive Director, the Chief of Information Technology, and sufficient staff to support them in carrying out their duties.

Section 13. Benefits

(a) Benefits shall include all healthcare determined by the Executive Director to be medically necessary, as defined in Section 1 (Definitions), including but not limited to:
  (1) Laboratory and imaging services;
  (2) Outpatient and inpatient care for injuries and acute or chronic diseases;
  (3) Emergency care for injuries and acute or chronic diseases;
  (4) Surgical care for:
    (i) Acute conditions, including but not limited to:
      - Incarcerated hernia;
      - Acute appendicitis;
      - Total bowel obstruction;
      - Cardiac tamponade;
      - Fractured bones requiring decompression or medically necessary immediate internal fixation;
      - Avascular necrosis;
      - Increased intracranial pressure.
    (ii) Non-acute conditions, including but not limited to:
      - Osteoarthritis requiring medically necessary joint replacement;
      - Heart failure requiring medically necessary cardiac assist devices;
      - Cochlear implants;
      - Breast augmentation after medically necessary surgical mastectomy, but cosmetic breast augmentation shall not be covered;
      - Breast reduction for symptomatic gigantomastia.

(iii) Congenital conditions, including but not limited to:
- Imperforate anus;
- Omphalocele;
- Hydrocephalus;
- Congenital heart disease;
- Spina bifida;
- Cleft lip;
- Cleft palate.

(iv) Organ failure requiring transplantation, including but not limited to:
- Kidneys;
- Liver;
- Heart;
- Lungs.

(v) Fetal abnormalities or conditions threatening fetal harm that are amenable to intrauterine surgical treatment, including but not limited to:
- Amniotic band syndrome;
- Bronchopulmonary sequestration of the lung;
- Congenital cystic adenomatoid malformation of the lung;
- Lower urinary tract obstruction;
- Mediastinal or sacrococcygeal teratoma.

(5) Non-surgical Intrauterine care provided to a beneficiary's embryo or fetus, independent of the beneficiary's personal healthcare needs;
(6) Prenatal, perinatal, and maternity care by licensed healthcare professionals, including but not limited to obstetricians, midwives, and doulas;
(7) Family planning, fertility, and reproductive healthcare, including but not limited to in vitro fertilization, abortion, and birth control by methods including but not limited to vasectomy, tubal ligation, intrauterine device or other obstructive device, and medication to produce infertility;
(8) Medically necessary anesthesia for surgical, medical, or diagnostic services;
(9) Dental services, including but not limited to routine dental care, dental implants, and medically necessary orthodontics but excluding cosmetic dentistry;
(10) Vision evaluation and correction, including but not limited to glasses, contact lenses, and laser vision correction but excluding interventions solely for cosmetic purposes;
(11) Hearing evaluation and treatment, including but not limited to hearing aids and cochlear implants;
(12) Mental health services, including outpatient and inpatient care;
(13) Behavioral health services, including outpatient and inpatient care;
(14) Substance abuse services, including outpatient and inpatient care;
(15) Orthotics, including but not limited to mechanical or electronic devices and their surgical implantation, if required, and training in an outpatient or inpatient facility;
(16) Prevention of disease and injury through, but not limited to:
(i) Screening, counseling, and education;
(ii) Medically necessary laboratory studies and imaging;
(iii) Annual wellness examinations;
(iv) Dental hygiene performed no more than twice a year.

(17) Durable and non-durable equipment and supplies, as defined in Section 1 (Definitions), that are prescribed by medical professionals licensed or otherwise authorized to prescribe them.
(18) A second opinion, as specified in Section 1 (Definitions);
(19) Experimental medical care supervised by scientists with the approval of a human studies review board and financed at least partly by a government grant, subject to the Executive Director's approval or negotiation;
(20) Blood and blood products, including but not limited to:
- (i) Medically necessary transfusion of whole blood or blood components, including but not limited to plasma, packed red blood cells, lyophilized platelets, and platelet-rich plasma;
- (ii) Exchange transfusion to treat ABO hemolytic disease in a newborn;
- (iii) Treatment of anemia with packed red blood cells;
- (iv) Treatment of platelet deficiency with platelet-rich plasma or lyophilized platelets;
- (v) Preparation and storage of blood plasma, packed red blood cells, lyophilized platelets, and platelet-rich plasma by collecting whole blood and processing individual components.
- (vi) Freezing and storing blood products for future use.

(21) Medically necessary iontophoresis to treat hyperhidrosis;
(22) Casgevy treatment of sickle cell disease in patients 12 years and older;
(23) Rehabilitation services, including but not limited to physical, occupational, psychological, and other specialized therapies provided on a homecare, outpatient, or inpatient basis;
(24) Physical therapy;
(25) Occupational therapy;
(26) Home healthcare by nurses or other providers;
(27) Chiropractic care;
(28) Podiatric care;
(29) Acupuncture;
(30) Long-term institutional care when prescribed by a healthcare professional authorized to prescribe that benefit;
(31) End-of-life care, including but not limited to hospice care;
(32) Language interpretation for non-English speaking beneficiaries;
(33) Assistance for hearing-impaired beneficiaries, including but not limited to sign language and amplified voice.
(34) Assistance for vision-impaired beneficiaries, including but not limited to braille instructions and reading aloud.
(35) Emergency and other medically necessary transportation, including but not limited to land and air ambulance;
(36) Telemedicine services provided by healthcare professionals licensed in the state where they are located;

(37) Prescription drugs, as defined in Section 1 (Definitions):
   (i) The trust shall neither produce nor use a formulary because all prescription drugs shall be provided to beneficiaries without charge;
   (ii) The trust may purchase prescription drugs from American or foreign manufacturers or distributors, providing the drugs meet FDA standards;
   (iii) The trust shall outsource prescription drug delivery to one or more distributors, who will deliver drugs to beneficiaries' homes or other locations or make them available for pickup at local pharmacies.
   (iv) The trust shall choose prescription drug distributors by secret bidding and select the lowest bidder that can distribute prescription drugs with high quality and convenience to beneficiaries, as determined by the Executive Secretary.
      - All distributors shall be paid equally for prescription drug distribution.
      - Distributors unwilling to accept the lowest bidder's price may withdraw.
   (v) Contracts with distributors shall expire after one year, when the trust shall again choose distributors, including new ones, using the same method and meeting the same criteria specified in (iv) of this section;

(b) Beneficiaries shall have free choice of providers, as defined in Section 1 (Definitions).

(c) Beneficiaries shall be able to schedule appointments with eligible healthcare professionals without a referral from another healthcare professional.

(d) Healthcare professionals with appropriate clinical privileges at inpatient or outpatient healthcare facilities shall be able to schedule patients for inpatient or outpatient care without the approval of or referral from another healthcare professional.

Section 14. Benefits Advisory Committee

(a) The Executive Director shall, within two months of their appointment, appoint four providers to the Benefits Advisory Committee who have particular knowledge of the benefits, as specified in Section 13 (Benefits) and the methods for submitting claims for providing benefits, as specified in Section 11 (Provider Payment), based on nominations from:
   (1) The Massachusetts Medical Society, which will nominate one;
   (2) The Massachusetts Nurses Association, which will nominate one;
   (3) The Massachusetts Health and Hospital Association, which will nominate one;
   (4) The chair of the AMA CPT Healthcare Professionals Advisory Committee (HCPAC).

(b) The Executive Director shall be an ex officio member of the committee.

(c) The committee members shall serve a five-year term unless they resign or the Executive Director replaces them, with or without cause.
   (1) Upon completion of their term, the Executive Director shall replace them using the same method used to appoint them.

(d) The committee's primary purpose is to advise the Executive Director and trustees regarding provider payment, as specified in Section 11 (Provider Payment).

(e) The committee shall elect a chair at its first meeting by majority vote.
   (1) The chair shall serve until replaced at the end of their term or earlier by the Executive Director, with or without cause.
   (2) Replacement shall be as specified in (a) of this section.

(f) Committee meetings shall be scheduled to ensure a quorum of all four members.

(g) The committee's recommendations are usually determined by consensus, but in the absence of a consensus, a majority vote shall determine them. If a vote is tied at two for and two against, the Executive Director, who shall otherwise be a non-voting committee member, shall cast the deciding vote.

(h) The committee shall meet in person annually to review the methods for paying providers, as specified in Section 11 (Provider Payment), and recommend additions or modifications.

(i) The Executive Director shall prepare the agendas for the committee meetings in consultation with the chair.

(j) The chair shall preside over the committee meetings.

(k) A staff member shall prepare minutes of the committee meetings and distribute copies to each committee member within one week after the meeting.
   (1) The committee shall review and approve or correct the minutes remotely within three weeks of each meeting.

(l) Committee members shall be paid $1,000 and reimbursed for actual and necessary expenses for each full day of meeting attendance, provided the costs are not payable by another public agency. For this section, a full day of meeting attendance shall mean their presence at and participation in at least 75 percent of the total meeting time during any 24 hours.

(m) The Executive Director may call special committee meetings to address topics that require immediate attention.

(n) Special meetings may be virtual, in which case the Executive Director shall chair the meeting, members shall be paid $500 for participation, and no expenses shall be paid.

(o) The Executive Director and the trustees shall, at their discretion, adopt all or part of the committee's recommendations.

(p) All the committee's meetings shall comply with the Massachusetts Open Meeting Law, G.L. c. 30A, §§18-25.

Section 15. Quality Assurance

(a) The trust shall apply the principles of healthcare quality assurance identified and validated through rigorous scientific studies, including but not limited to:
   (1) Requiring healthcare professionals to adhere to the national standards of care, clinical guidelines, and best practices developed by the professional societies that represent them;
   (2) Requiring healthcare professionals to be licensed by a state licensing board;
   (3) Rewarding healthcare professionals for being certified by national boards of their medical specialty by demonstrating through written and oral examinations the superior knowledge required to provide beneficiaries with the highest possible quality of care;
   (4) Supporting the medical, nursing, and other state disciplinary boards in identifying healthcare professionals whose patient care does not meet national standards.
      (i) The disciplinary boards shall identify such inferior patient care by rigorously investigating patient, family, and other healthcare professionals' complaints via a telephone hotline or an online form.
         - Anonymous complaints shall not be investigated, but the identity of complainants shall be held confidential.
      (ii) The disciplinary boards shall conduct an adjudication process to determine the merits of investigated complaints.
      (iii) If the respondent is found guilty as accused, the board shall issue a penalty, the least serious of which will be a verbal warning. After that, the penalties will progress through a written warning, suspension of the respondent's license for a fixed period, and permanent revocation of the respondent's license.
         - Suspension of the respondent's license may be stayed so long as their performance remains unblemished, as determined by an agent of the disciplinary body paid for by the respondent to monitor their performance and report it to the disciplinary body. Whether stayed or not, the case shall remain on record.
         - Immediate summary suspension shall be invoked if the respondent is determined to have significantly jeopardized patient or public safety.

(5) The trust shall minimize human error and cost by using electronic methods:
   (i) To identify beneficiaries at points of service, as specified in Section 8(e)(1) (Information Management).
      - Conventional ID cards shall be issued only to beneficiaries who do not have a digital method to identify themselves as beneficiaries;
   (ii) For the Department of Revenue to receive claims for benefits and disburse payment to providers.
      - Providers shall not submit claims using paper-based forms.

(6) The trust shall require all healthcare professionals and facilities to use electronic medical records approved by the trust, which shall include but not be limited to:
   (i) The clinical records of beneficiaries;
   (ii) Computerized physician order entry (CPOE)
   (iii) Clinical decision support (CDS).

(7) The Chief of Information Technology, in consultation with the Benefits Advisory Committee and the Executive Director, shall establish standards for the safety and effectiveness of the electronic medical records the trust approves for use by providers.

(8) The trust shall require healthcare facilities to be accredited by a certified national accrediting organization (e.g., the Accreditation Association for Ambulatory Healthcare or the Joint Commission).

(9) The trust shall use all available Medicare quality improvement methods, including but not limited to:
   (i) Complying with the Medicare Access and CHIP Reauthorization Act (MACRA), which rewards physicians financially for providing beneficiaries with high-value benefits and penalizes them for providing beneficiaries with disproportionally large numbers of high-volume benefits.
      - High-value benefits, with a low cost-to-reward ratio, are desirable.
      - High-volume benefits are those that providers deliver frequently. A significantly higher number of high-volume benefits, as identified by a comparison of a provider's average with the average number delivered by similar providers for similar benefits nationally, suggests that the provider may be fraudulently delivering benefits that are not medically necessary to inflate compensation at the expense of the insurer.
      - The rewards and penalties addressed in (a)(9)(i) of this section shall be determined with the Merit-Based Incentive Payments System (MIPS), which gives bonus payments to physicians for participating in eligible alternative payment models (APMs), whose scores are determined from information reported by physicians on (1) quality measures, (2) cost measures, (3) health information technology use, and (4) practice improvement activities.
      - CMS calculates a score of 0-100 for each physician, group, or APM and compares the score to a performance threshold to determine the applicable bonus or penalty amount to be applied to their Medicare payments for two years after the performance data are collected.
   (ii) Participating in the Medicare Quality Improvement Organization (QIO) Program established by the Centers for Medicare & Medicaid Services

(CMS), which aims to improve healthcare quality, access, value, and equity for beneficiaries by:

- Using data to track healthcare quality improvements at the local level;
- Protecting the integrity of the Massachusetts Medicare for All Trust Fund by ensuring that the trust pays only for services and goods that are reasonable, necessary, and provided in the most appropriate setting;
- Protecting beneficiaries by expeditiously addressing complaints from beneficiaries, their families, and others;
- Investigating suspected violations of the Emergency Medical Treatment and Labor Act (EMTALA).

(10) The Department of Health shall investigate cases of healthcare quality reported as not meeting national standards of care and, if national standards have not been met, impose sanctions, including but not limited to financial penalties and the requirement for a facility found culpable to provide the department with a corrective action plan.

(i) The department may require a culpable facility to pay a monitor to regularly report on its progress with achieving the plan for corrective action until all deficiencies have been permanently corrected.

Section 16. Cost Control

(a) The Secretary shall develop regulations and incentives to minimize the trust's costs, including but not limited to encouraging:

(1) Healthcare professionals to prescribe generic drugs that are as safe and effective as brand-name drugs;

(2) Healthcare facilities to purchase drugs, durable equipment, and nondurable supplies directly from manufacturers without using any middlemen;

(3) Beneficiaries to request and accept generic drugs prescribed by healthcare professionals;

(4) Healthcare professionals, healthcare facilities, and pharmacies to educate beneficiaries about the cost savings of generic drugs that are as safe and effective as brand-name drugs;

(5) Beneficiaries to seek preventive healthcare services to provide early detection and intervention to reduce the costs of preventable medical conditions;

(6) Beneficiaries to engage in weight reduction, healthy eating habits, and physical activities to reduce their healthcare risks.

Section 17. Regulations

The Executive Director shall develop regulations to administer this chapter.

(1) The initial regulations may be adopted as emergency regulations, which shall be in effect for up to one year after this bill is enacted.

(2) After that, the Executive Director shall use a system for developing regulations that involves input from all interested parties.

Section 18. Implementation

(a) The Secretary shall appoint a search committee to conduct a nationwide search for an Executive Director within one month after this bill is enacted.

(b) The Secretary shall appoint an Executive Director within three months after this bill is enacted.

(c) The Executive Director shall appoint a Chief of Information Technology, who shall take office within four months after this bill is enacted.

(d) The Executive Director, within four months after this bill is enacted, shall begin a statewide search for economists familiar with healthcare financing to be appointed to the Economic Advisory Committee within another two months.

(e) The information technology division shall identify several electronic methods for beneficiaries to identify themselves without a conventional plastic ID card within ten months after this bill is enacted.

(f) The information technology division shall deliver to the Department of Revenue within ten months after this bill is enacted methods for:
  (1) The department to electronically collect the taxes specified in Section 4 (Funding Sources);
  (2) Providers to electronically submit claims for payment;
  (3) The department to pay providers, as specified in Section 11 (Provider Payment);
  (4) The department to account for receivables and payables related to the payment of providers.

(g) The Department of Revenue Finance shall, within 12 months after this bill is enacted, implement the electronic methods developed by the information technology division for:
  (1) The department to electronically collect the taxes specified in Section 4 (Funding Sources);
  (2) Providers to electronically submit claims for payment;
  (3) The department to pay providers, as specified in Section 11 (Provider Payment);
  (4) The department to account for receivables and payables related to the payment of providers.

(h) All Massachusetts residents shall automatically be enrolled in Massachusetts Medicare for All within 12 months after this bill is enacted unless they are beneficiaries of federal healthcare programs, as specified in Section 9(e) and (f) (Beneficiaries).

(i) Massachusetts Medicare for All shall be fully implemented within 12 months after this bill is enacted.