MASSACHUSETTS

2012 Payment Reform Legislation
Chapter 231, Section 60L and Section 85K; Chapter 233, Section 79L
(text available at https://malegislature.gov/Laws/GeneralLaws/PartIII/TitleII)

Intention Behind the Legislation: The MA 2012 Payment Reform Legislation liability provisions were negotiated and enacted to encourage the development of the "disclosure, apology and offer" model ("DA&O") more recently known as communication and resolution programs ("CRP") for resolution of claims following medical injury.

Development of the Legislation: In 2010, the Massachusetts Medical Society ("MMS") along with the Beth Israel Medical Center was awarded an AHRQ planning grant to develop a Roadmap for implementation of a CRP model in MA. Interviews with key stakeholders identified barriers to the development of such a program as well as strategies to overcome them. The MMS then engaged the Mass Bar Association and the Mass Academy of Trial Attorneys to negotiate consensus legislative language for the 2012 Payment Reform Legislation to facilitate CRP adoption. The Massachusetts Alliance for Communication and Resolution following Medical Injury (https://www.macrmi.info/) was established to implement the Roadmap.

Summary of Process.

Mandatory versus Optional: Mandatory process

Initiation of the Process: While the vast majority of CRP cases in Massachusetts are identified within the organization or by the patient or family (96%), under this statute, in order to initiate a legal process, the claimant must provide notice to the health care provider.

Oral versus Written: Both the claimant's notice and the health care provider's response must be written

Timing:

1. The claimant's notice must be sent 182 days (shortened to 90 days in specified circumstances) prior to commencing legal action against a health care provider
2. The claimant must allow the health care provider access to all related medical records no later than 56 days after providing notice
3. The health care provider/authorized representative must provide a written response within 150 days after receiving the claimant's notice

Disclosure Required:

1. The notice sent by the claimant **MUST** contain **(i)** the factual basis of the claim, **(ii)** the applicable standard of care, **(iii)** how that standard of care is alleged to have been breached, **(iv)** what action should have been taken, **(v)** how the breach of the standard of care was the proximate cause of injury, and **(vi)** all named health care providers
2. The health care provider's response **MUST** contain **(i)** the factual basis of the defense, **(ii)** the applicable standard of care, **(iii)** how the provider was/was not in compliance with that standard of care, and **(iv)** how the alleged negligence was/was not the proximate cause of the claimant's harm

Additional Features: Statements of apology, regret, mistake, error, general sense of concern made by a health care provider are not admissible in a judicial or administrative proceeding (unless there are contradictory/inconsistent statements). Full disclosure is required in cases of unexpected medical complications caused by provider mistake. The cap on medical malpractice claims against non-profit healthcare organizations was increased to $100,000.

Statute of Limitations: No tolling of the statute of limitations; the legislation does NOT apply to lawsuits filed within 6 months of the expiration of the statute of limitations or within 12 months of the expiration of the statute of repose.

Impact on Future Litigation: If the health provider fails to respond in a timely manner, litigation can commence after the 150-day time period has ended AND interest on any future judgment will start accruing from the date the initial notice was sent rather than the date of the judgment.